Investigation into the circumstances surrounding the death of a man at HMP Blakenhurst in May 2004

Prisons and Probation Ombudsman for England and Wales

August 2005

This is the report of an investigation into the death of a man, at the age of 30 years, at HMP Blakenhurst on 18 May 2004. He was on remand, accused of the murder of his partner and two daughters in December 2003. He had been in the prison since January 2004.

The events from December 2003 that ended with the man's death in May 2004, will have caused enormous pain and grief to the people involved. I offer my condolences to those touched by these tragedies

The purpose of the investigation was to establish the circumstances and events surrounding his death, including the quality of care provided by the Prison Service. There have been eight other self inflicted deaths in Blakenhurst since August 2002. Four of these occurred in Lower Medical, the Blakenhurst hospital wing where the man died. The investigation was also tasked with looking at the outcome of the Prison Service investigations into these other deaths, to see whether there were any underlying patterns or problems which the prison needed to tackle.

A key part of the investigation was to make sure that the family had the opportunity to raise any concerns about his death. The investigation team was in touch with the man's father, but he said that he did not have any worries about the way his son was dealt with by the Prison Service, and that he did not want to be involved in the investigation.

As Ombudsman, I took over responsibility for investigating deaths in prison custody in April 2004. Under transitional arrangements in force until 30 November, a senior investigating officer (SIO) was appointed by the Prison Service to report to me. In this case, this was the Governor of HMP Stafford. She was assisted by three members of staff, also from Stafford prison, and one from HMP Birmingham. I am grateful to them all for the work that they have done. The SIO's report is of a particularly high standard and I am indebted to all involved. A colleague from my office oversaw the investigation.

I would like to express my thanks to the Governor of Blakenhurst, and his staff, for the help and active co-operation that the investigators received during the investigation. This was a major piece of work, and the investigation inevitably put additional pressures on already over-stretched staff.

I am also grateful to the Director of Nursing and Clinical Services at Worcestershire Mental Health Partnership NHS Trust, for the very thorough and helpful Clinical Review he conducted, as part of the investigation, into the medical care provided to the man who died. He too was assisted by a number of health care professionals – the Deputy Director of Public Health, Director of Corporate Affairs and Communications, and Clinical Governance Co-ordinator, all from Redditch and Bromsgrove PCT, the Healthcare Manager at HMP Brockhill, and Head of Risk Management at Worcestershire NHS Support Services Agency. Again, I should like to commend the standard of Clinical Review.

This report concludes that there were a number of failings in the way the prison and other agencies managed both the man's desire to commit suicide and the health care he received. But perhaps my gravest concern is that not all the problems identified from investigations into previous deaths have been resolved. I have made a number of recommendations, and I urge the Prison Service to ensure that these are now most vigorously pursued.

STEPHEN SHAW CBE
PRISONS AND PROBATION OMBUDSMAN

August 2005

Contents

Ombudsman's summary

The man

The man at the centre of my investigation was born in 1974, and was 30 years old when he died at HMP Blakenhurst on 18 May 2004. He had been remanded in custody on 9 January 2004, accused of the murder of his partner and their two daughters on 24 December 2003. He was subsequently involved in a car accident, which appeared to be an attempt to kill himself, and sustained a broken leg and stab-type wounds. He was treated at hospital before being transferred to Blakenhurst.

On 9 January 2004, a Community Psychiatric Nurse from Telford Mental Services opened a suicide warning form (an F2052SH). The man was put on a level two watch (five times an hour). On reception at Blakenhurst later that day, he was admitted to the prison hospital, known as the Lower Medical, both because of his broken leg and for a mental health assessment. A mental health assessment, which said he was "excitable and confused" and a risk assessment, which identified the risk of self harm, were completed. Neither document was signed or dated. The mental health assessment did not indicate if follow-up action was required.

On 10 January, he asked for a 'lethal' injection. At 10.30am he was assessed by a prison doctor and placed on a constant watch during the night, in a gated cell, and close observations during the day. An unsigned and undated care plan identified five areas for nursing action. There was no date identified for this to be reviewed.

The F2052SH was reviewed by a multi-disciplinary team on 12 January. The man was to remain on constant watch at night and a level two watch during the day. There was a further review on 13 January.

Specialist mental health assessments

A Specialist Registrar from Reaside Forensic Psychiatry Service saw the man on 15 January and assessed him as having severe depression. He recommended a possible transfer to a high security hospital, but with an initial referral to the Reaside Clinic for further assessment by a Consultant Forensic Psychiatrist. The Reaside Clinic is a medium secure mental health unit, which provides psychiatric services to Blakenhurst through visiting specialists.

It does not appear that he was ever seen by a Consultant Forensic Psychiatrist, although he was assessed by various other specialists from Reaside Clinic. A review by another Specialist Registrar on 20 January noted a reactive depression, and that he described psychotic symptoms. On 21 January, a Senior House Officer and Senior Nurse Walsh, both from the Reaside Clinic, reviewed the man's case. They reported no overt psychosis, not much evidence of clinical depression, and a probable adjustment disorder.

Also on 21 January, Blakenhurst reviewed the man's F2052SH. He was eating and sleeping normally, although still having difficulty coming to terms with what had happened. He was moved to a level three watch (hourly). But he seemed to deteriorate, and on 26 January his F2052SH was reviewed again, and he was put back on a level two watch. However, this level of observations does not appear to have been carried out.

Transfer to the wing

On 28 January, the man was moved from the healthcare centre to Houseblock 5, the vulnerable prisoners' unit, into a shared cell. The Senior Medical Officer at the prison, wrote in the discharge report that he thought the man should remain on suicide watch indefinitely. He was to have a follow-up appointment with a psychologist. A review of the F2052SH on 28 January reduced the level of watch to three. There was a further review on 3 February.

7 February was the date of the funeral of the man's partner and children. The watch was raised from level three to level two for a short period.

At the weekly case review of the F2052SH on 12 February, he was tearful and upset. It was agreed that he would be provided with 30 minutes bereavement counselling each day. After the review he was seen for about an hour by members of the prison's Mental Health In-Reach Team.

On 12 and 13 February, the Mental Health In-Reach Team assessed him. They concluded that he did not have a severe and enduring mental illness, and referred him for support from healthcare staff at the prison's Registered Mental Nurse clinic.

His case was reviewed again on 19 February and 26 February. The level three watch was continued. He was offered Listener support, and it was noted he needed further support with bereavement.

On 29 February, a prison psychologist assessed the man. The psychologist concluded that there was no evidence of mental illness or major depressive symptoms, and recommended further counselling.

On 2 March, the man was thought to have been passed drugs on a visit. He was put in the segregation unit, but returned to the wing that evening. He was put on a closer watch that night. On 5 March there was an adjudication, and he was given a caution.

The man's case should have been reviewed on 4 March, but despite the omission being identified by the Orderly Officer every night between 7 and 10 March, this did not happen.

F2052SH closed

The next review took place on 11 March, and the F2052SH was closed on the grounds that the man had been working and no longer felt suicidal. There was no healthcare input to the review, and a conversation the man had had the previous day with healthcare staff, when he said he was low, depressed and having nightmares, was not communicated to the review team. A Senior Officer on the wing said it was usual to do reviews without healthcare staff, because of the difficulties of finding any healthcare staff with the time to spare. The support plan for the man included continuing support from Chaplaincy and the Mental Health In-Reach Team, and bereavement counselling. The Senior Officer said at interview that the man was getting a lot of support from the Chaplaincy at that time, although contact from the In-Reach Team had dwindled. It does not appear that he was ever given any formal bereavement counselling, although the Chaplains say they would have talked to him informally.

A further assessment by the psychologist on 19 March confirmed that the man was not mentally ill, but recommended continuing support. He was seen later that day in the prison's Registered Mental Nurse clinic for support.

Change of mental health diagnosis

On 6 April, the man was reviewed at the Registered Mental Nurse clinic. His presentation was notably different. The prison's Mental Health In-Reach Team were contacted, and an assessment by the team's psychiatrist was arranged for 16 April. A follow-up appointment at the Registered Mental Nurse clinic was arranged for 20 April.

On 16 April, the prison psychiatrist conducted the mental health assessment. She found the man who is the subject of this report to be actively psychotic, and a high risk to others. She wanted a doctor from Reaside Clinic to see the man and transfer him to Reaside if he thought a secure hospital admission to be appropriate. The psychiatrist immediately faxed a referral to the doctor. She said at interview that the referral process to Reaside was very cumbersome, and there was no formal mechanism for finding out what Reaside intended to do. It seems that doctor who was contacted did not in fact ever see the man.

Following the prison psychiatrist's assessment, the man's cell sharing risk assessment was reviewed. He was considered to be a high risk to other prisoners due to his unpredictability, and from then on he was kept in a single cell.

On 20 April, the man's appointment at the Registered Mental Nurse clinic was cancelled due to staff shortages. On 23 April, he made cuts to his arm with a razor blade. His F2052SH was not reopened. Also on 23 April he was assessed by a forensic psychiatrist from the Reaside Clinic. The prison psychiatrist says that the forensic psychiatrist saw the man as a private referral from his solicitors for a court report, and not on behalf of Reaside

Clinic in response to her request. The forensic psychiatrist said the man was experiencing auditory hallucinations, and recommended he be readmitted to healthcare for observation. He also suggested various other tests, including a drugs screen, and he said he would liaise with the doctor (whom the prison psychiatrist had previously faxed) as they were both at Reaside. The prison psychiatrist says that the doctor wanted the man who died moved to a situation of maximum security for assessment.

The man remained on the wing. There is no evidence that the tests recommended by the doctor were done.

On 26 April, laces that the man said were for hanging bottles outside his cell were removed. Over the next few days, he was reported to be expressing bizarre thoughts.

On 5 May, the Reaside Clinic had a meeting where the man was discussed. Arrangements were made for a further assessment, and the possibility of a referral for a high security placement was discussed.

On 6 May, he damaged his television, but was not put on report because of his mental state. On 7 May, his medication was increased as he was showing psychotic symptoms.

New F2052SH opened

On 8 May, the man cut his arm again, and a noose was found in his locker. An Officer on Houseblock 5 therefore opened a new F2052SH, and the man was placed on level three watch. There was no nursing assessment. He was to be supported by the Chaplaincy and Listeners, and included in domestic work. It appears that only the Listener support was put in place.

Once opened, there was no further review of the F2052SH. It does not appear that the man was asked if he would like his next of kin to be contacted, as procedures require.

On 9 May, a prison doctor saw the man and assessed him as being grossly psychotic. The doctor said that he should be on the same level of observations as before. On 10 May, the man was banging his head against the wall and complaining of hearing voices. He was moved back to Lower Medical.

On 11 May, he attended a hospital appointment about his leg. His F2052SH did not travel with him. Escort staff say that the man expressed bizarre thoughts, but this was not recorded.

On 13 May a visiting Senior Community Psychiatric Nurse from the Reaside Clinic, saw the man. The Nurse decided that the man should be discussed at the next clinical team meeting, with a view to referral to a Consultant Forensic Psychiatrist at Reaside.

Later that day, the forensic psychiatrist from Reaside who had previously seen the man assessed him again, and recommended that he be transferred to hospital for assessment and treatment under the Mental Health Act. The forensic psychiatrist was to liaise with the Senior Community Psychiatric Nurse and the doctor from the Reaside Clinic. The man was not considered to be fit to plead in the forthcoming court case. Subsequently, he continued to exhibit psychotic symptoms.

On the night of 17 May there were five other prisoners in the Lower Medical on an open F2052SH. Two of these were on constant watch. The man and the prisoner in the adjacent cell were on level three observations and considered to be the lowest risk of the five prisoners.

Events on 18 May

At about 9am on 18 May, the man was up, which was unusual, and seemed in a good mood. He had a shower, and made some strange comments. He said that he had been at work all night, and that he was not sure what 'this place' was. He asked when he would see a psychiatrist. He subsequently spoke to two other prisoners in the pool room, and they left him there at about 10.55am. One of these prisoners said at interview that he thought another prisoner, the one in the adjacent cell to the subject of this report, had been bullying the man because of his alleged offences. The man returned to his cell at about 11.30am.

Video footage shows the prisoner thought to be bullying the man subsequently going into the man's cell, where he stayed for one minute before going to the association room. At 11.33am, the prisoner stood in the middle of the landing, then checked another cell and returned to the offices. At 11.35am he went to the man's cell. The tape shows the prisoner bent over, apparently facing the cell hatch and then jerking upwards three times before reaching in through the hatch. He then walked away from the door.

The prisoner then shouted to staff that the man was hanging off the back of the door, and Healthcare Assistant and an Officer went to the man's cell. There was a ligature under the hinges of the cell hatch, which was open. The man was hanging on the other side. They pushed into the cell, and Health Care Assistant cut the ligature.

Attempts by staff to resuscitate the man were unsuccessful. He was pronounced dead at 11.53am by the prison's Senior Medical Officer.

Later on 18 May, the police interviewed the prisoner who was allegedly bullying the man who died. He was subsequently declared unfit for further interview. The police were not able to conduct a second interview until September. A file has been prepared for the Crown Prosecution Service, and a decision on whether there is evidence for the prosecution of this prisoner is awaited.

After the man's death, all relevant staff and prisoners were offered a commendable level of support. Prisoners particularly praised the Deputy Governor for her caring and supportive approach.

Later on 18 May, the father and a friend of the man who died, were at the Visitor's Centre on a pre-planned visit. The Deputy Governor and a Chaplain (the Safer Custody Manager at the prison) went to see them to break the news.

Prison Service suicide prevention arrangements

Prison Service Order 2700 sets out what prisons must do in relation to prisoners at risk of suicide or self harm. In particular:

Action following incidents of self harm

An F2052SH must be opened following any act of self harm.

Health care assessment

Following an initial referral to a health care officer, the prisoner must be referred to a doctor as soon as possible, and in any event within 24 hours of any referral to health care.

Case reviews

- All prisoners for whom the prison has opened an F2052SH must have their cases reviewed within 72 hours.
- Reviews should also take place following incidents of self harm or attempted suicide.
- All reviews should be multi-disciplinary.

Contact with the next of kin

- Following an act of self harm, and after consultation with the prisoner, the nominated next of kin must be notified, unless there is a clinical reason not to, or the prisoner does not consent, or the prisoner's support plan indicates otherwise.

Other deaths at Blakenhurst

Since July 2002 there have been nine other deaths in Blakenhurst. Eight of these were self inflicted and, of these, four occurred in Lower Medical. These deaths were all investigated by the Prison Service. The investigation reports made a number of recommendations, not all of which have been implemented.

Recommendations relevant to arrangements for dealing with prisoners at risk of suicide included:

Policy and procedures

- The Suicide Prevention Policy, and F2052SH procedures, require urgent review, and guidelines must be followed.
- In relation to F2052SH processes, Blakenhurst should improve:
  - Multi-disciplinary representation at reviews.
  - Meeting deadlines of reviews.
  - Provision of support plans, including when the file is closed.

Review of action plans

- Consolidated points from the death in custody action plans should form a standing agenda item at the local Suicide Prevention Strategy meeting.

Training and quality control

- The Suicide Prevention Team should review training and quality control measures for the F2052SH process and agree an action plan with the Governor as to how and when this will take place. There should be a co-ordinated system of management checks on F2052SH documentation, and further training for staff.
- The check of current F2052SH files should be more rigorous.
- The Suicide Prevention Committee should review each closed F2052SH at their meetings.

Recommendations about cells

- More shared cells should be available in Lower Medical.
- The Governor should consider the case for more safer cells.
- Where a prisoner at risk of self harm is placed in a single cell, other measures such as the level of observation or provision of a safer cell should be considered to reduce risk.
- The Governor should press for a cell bell recording system which would show when a prisoner has called for attention, and record staff observations on those at risk of self harm.

Other recommendations

- The prison should seek opportunities to develop a supportive environment for potentially suicidal prisoners.
- Priority should be given to the co-ordination of action plans for all death in custody reports.

Some of these recommendations were made in more than one investigation.

Suicide prevention at Blakenhurst

The investigation team looked at current suicide prevention arrangements. They found that Blakenhurst's latest suicide prevention strategy was produced in 2002. During the course of this investigation, a new policy was produced.

The Suicide Prevention meeting did not review the quality of F2052SH files, and attendance was irregular. There also appeared to be significant gaps in the training provided to staff. The investigation team concluded that a number of recommendations from previous death in custody investigations had not in fact been implemented.

There were also some suggestions of difficulties with Listeners accessing Lower Medical, despite the Service Level Agreement with the NHS, which requires a Listener to be available 24 hours a day in the health care centre. There appears to have been a particular problem at night. However, the Samaritans representative said during the course of the investigation that this was improving.

Health care

Health services in Blakenhurst are provided by the local NHS. The Health Care Centre is managed by a Senior Nurse Manager. Management of operational matters relating to health care, such as the movement of difficult prisoners, is the responsibility of a Governor.

The NHS employs a team of Registered General Nurses, Registered Mental Nurses and Health Care Assistants. The Reaside Clinic, a medium secure unit, provides psychiatric services through visiting specialists.

Both the investigation and the Clinical Review identified a number of problems with the health care provided on Lower Medical.

The majority of prisoners admitted to Lower Medical suffered from acute mental health problems, but a lack of focus meant that their needs were not always being met.

The fact that nurses worked in a single team meant that there was no predictable mix of General Nurses and Mental Nurses on any specific day, despite the serious mental health problems of many of the prisoners. The skills mix was also insufficient to allow a Registered Mental Nurse to be available at all times. The Clinical Review also identified concerns that some of the Registered Mental Nurses did not have recent experience of working with acutely mentally ill patients. In addition, low staffing levels in Lower Medical meant that it was common for the prisoners' regime to be curtailed, and they were kept locked up for long periods.

Prisoners did not have their own named nurse. The Clinical Review also expressed concern about the lack of a care co-ordination system.

There has been a long standing problem of getting prisoners seen by Reaside staff, whose attendance at Blakenhurst was erratic, and arranging for them to

be transferred on to secure accommodation. There was also a problem of communication between the prison and Reaside. In particular, the forensic psychiatrist seemed to have stopped visiting, and there were no mechanisms for making sure the prison was kept up to date with progress on referrals.

All the cells in Lower Medical are used for single occupancy. This clearly presented problems for the care of some prisoners at risk of self harm.

Conclusions and recommendations

The man who is the subject of this report was accused of a horrendous crime, and he was bound to be a high suicide risk. The prison recognised this at the start of his time in prison, and arranged for him to be closely managed, and for his psychological state to be assessed. At that point, he was not considered to have any serious mental disorder. There were some procedural flaws in the way Blakenhurst dealt with him in those early days, to which I shall return, but I am not convinced that they influenced the eventual outcome.

By early April the situation had changed dramatically. On 16 April, the prison's Mental Health In-Reach Team psychiatrist assessed the man as being actively psychotic and a high risk to others. He was referred immediately to the Reaside Clinic with a view to considering whether a secure hospital admission might be appropriate, and was located in a single cell at the prison.

The prison psychiatrist's view was confirmed by the subsequent psychiatric assessment that was arranged by the man's solicitors for a court report. But the very poor liaison arrangements between the prison and the Reaside Clinic, and erratic attendance at the prison by Reaside staff, meant that there was no urgent or co-ordinated action in relation to the deterioration of the man's condition. Indeed, Reaside appeared to operate in a vacuum with no one person taking responsibility for overseeing the care of him. So Blakenhurst was left to manage at best it could with a suicidal and psychotic prisoner.

Recommendation: I recommend that the Governor works with the Primary Care Trust (PCT) and Reaside Clinic to develop a service level agreement between the PCT, the prison and the clinic, clearly articulating the roles and responsibilities of forensic services and identifying a named individual as the key communication link.

Although I appreciate that Blakenhurst was faced with a difficult task, I do not consider that it did all that it should have done to safeguard the man who died. No action was taken about the risk of suicide after he made cuts to his arm on 23 April. The F2052SH was not reopened until 8 May. Whilst there is no automatic requirement for referral to heathcare, his history should have prompted one. No nursing assessment was done at that time. The F2052SH was never reviewed once it was opened. So there was no check of the support plan, and the plan was not in fact fully implemented. There is no evidence that the man was asked, after his self harm attempts, whether he wanted his next of kin contacted, as prison procedures require. When he left the prison to attend hospital, the F2052SH did not travel with him as it should have done, and observations of staff during this time were therefore not recorded in it.

There were also procedural flaws in the way Blakenhurst administered the first F2052SH. The agreed level of observations were not always carried out. The review of 4 March was missed, despite several reminders from the

Orderly Officer. The decision to close the F2052SH was not made at a multidisciplinary meeting as procedures require and, crucially in the man's case, there was no health care input into the decision. The support plan during the time of the first F2052SH, and after its closure, was not fully implemented.

Many of these failings – for example, the lack of multi disciplinary representation at reviews, the meeting of deadlines for reviews, and the provision of support plans - were also identified in previous investigations into deaths at Blakenhurst. It is a matter of concern that the problems still do not appear to have been resolved. While I welcome the fact that, during the course of the investigation of the man's death, Blakenhurst updated its suicide prevention strategy, my view is that the prison still needs to undertake a thorough review of its arrangements. This should include making sure that all the actions from this and previous investigations are properly considered, and implementation plans drawn up and monitored. The prison should also ensure that there is 24 hour access to Listeners for prisoners, including those in Lower Medical.

Recommendation: I recommend that the Governor reviews the suicide prevention arrangements, and ensures that all actions from this and previous investigations are considered, and implementation plans drawn up and monitored.

One element of the support that it was agreed would be provided for the man and appears at most only to have been provided on an informal and ad hoc basis, was bereavement counselling. Formal bereavement counselling might have helped him come to terms with his situation, and is likely to be particularly relevant to prisoners charged with, or convicted of, murdering family members.

Recommendation: I recommend that the Governor investigates the possibility of making a professional bereavement counselling service available to prisoners.

The recommendations of the psychiatrist arranged by the man's solicitors – that he be readmitted to heath care and that various tests including a drugs screen be performed – do not seem to have been considered and were not acted upon. As mental illness can be seriously compromised by the use of illicit substances, it was particularly important that the drug screening was undertaken.

Recommendation: I recommend that the Governor and the PCT review the drug screening policy and process both within health care and the wider prison.

Recommendation: I recommend that the Governor and the PCT consider ways of ensuring that recommendations made by specialists are promptly followed up.

I am satisfied that, once the man who died was found on 18 May, staff took all appropriate action, and both staff and prisoners were offered a commendable level of support. The Deputy Governor played a particularly supportive role.

Recommendation: I recommend that the Governor ensures that staff are aware of my view that appropriate action was taken after the man was found, and that he particularly commends the actions of the Deputy Governor.

I will turn now to other concerns about the medical care that the prison provided to the man who died, and particularly the findings to emerge from the Clinical Review.

Both the Clinical Review and the investigation identified that the role and remit of Lower Medical was confused and poorly focussed. The majority of people admitted to Lower Medical suffered from acute mental health problems and were managed alongside people with physical illness and, on occasions, with 'difficult to manage' prisoners.

Recommendation: I recommend that Governor and the PCT review the current service specification, clearly defining the role and remit of Lower Medical in relation to the care and treatment of prisoners with acute mental health problems.

The skills mix within the health care team was insufficient to allow for a Registered Mental Nurse to be available around the clock, which means that the most vulnerable prisoners are denied access to appropriate levels of treatment and support. In addition, some existing staff did not have recent experience of working with acutely mentally ill people.

Recommendation: I recommend that the Governor and the PCT commission a skills mix review, to make sure that the needs of mentally ill prisoners are met.

Recommendation: I recommend that, as a matter of urgency, the Governor and the PCT work together to ensure that additional Registered Mental Nurses, with recent experience of working with acutely mentally ill people, are appointed to Lower Medical.

The standard of documentation in Lower Medical fell short of acceptable professional practice, with a notable absence of appropriate care planning and risk assessment documentation. Where documents were available, they were often not signed and dated, and frequently were not person centred.

Recommendation: I recommend that the Governor and the PCT commission an audit of medical and nursing records to ensure compliance with PCT policies and standards of record keeping.

Recommendation: I further recommend that a more appropriate system of care planning and clinical risk assessment is adopted. Before implementation, training should be provided to all Registered Mental Nurses.

The health care team did not operate a named nurse or care co-ordination system.

Recommendation: I recommend that the Governor and the PCT develop, as a matter of urgency, a named nurse system. In addition, care co-ordination principles should be adopted for prisoners who have severe and enduring mental illness.

Finally, it appears that the nature of the charges against the man might have meant that he faced difficulties with other prisoners on Lower Medical. There may be a need to consider whether there is adequate protection for vulnerable prisoners on Lower Medical.

Recommendation: I recommend that the Governor reviews the arrangements for the protection of vulnerable prisoners on Lower Medical.

SUMMARY OF RECOMMENDATIONS

Recommendation: I recommend that the Governor works with the Primary Care Trust (PCT) and Reaside Clinic to develop a service level agreement between the PCT, the prison and the clinic, clearly articulating the roles and responsibilities of forensic services and identifying a named individual as the key communication link.

Recommendation: I recommend that the Governor reviews the suicide prevention arrangements, and ensures that all actions from this and previous investigations are considered, and implementation plans drawn up and monitored.

Recommendation: I recommend that the Governor investigates the possibility of making a professional bereavement counselling service available to prisoners.

Recommendation: I recommend that the Governor and the PCT review the drug screening policy and process both within health care and the wider prison.

Recommendation: I recommend that the Governor and the PCT consider ways of ensuring that recommendations made by specialists are promptly followed up.

Recommendation: I recommend that the Governor ensures that staff are aware of my view that appropriate action was taken after the man who

died was found, and that he particularly commends the actions of the Deputy Governor.

Recommendation: I recommend that the Governor and the PCT review the current service specification, clearly defining the role and remit of Lower Medical in relation to the care and treatment of prisoners with acute mental health problems.

Recommendation: I recommend that the Governor and the PCT commission a skills mix review, to make sure that the needs of mentally ill prisoners are met.

Recommendation: I recommend that, as a matter of urgency, the Governor and the PCT work together to ensure that additional Registered Mental Nurses, with recent experience of working with acutely mentally ill people, are appointed to Lower Medical.

Recommendation: I recommend that the Governor and the PCT commission an audit of medical and nursing records to ensure compliance with PCT policies and standards of record keeping.

Recommendation: I further recommend that a more appropriate system of care planning and clinical risk assessment is adopted. Before implementation, training should be provided to all Registered Mental Nurses.

Recommendation: I recommend that the Governor and the PCT develop, as a matter of urgency, a named nurse system. In addition, care co-ordination principles should be adopted for prisoners who have severe and enduring mental illness.

Recommendation: I recommend that the Governor reviews the arrangements for the protection of vulnerable prisoners on Lower Medical.

There are further recommendations of a more detailed nature in the Senior Investigating Officer's report.

Response from the Prison Service

I am glad to be able to say that, in his response to my draft report, the West Midlands Area Manager has accepted my recommendations, and that the Governor will take the necessary action. The Area Safer Custody Adviser will also now review all the previous recommendations from death in custody recommendations.

DEATH IN CUSTODY

HM PRISON BLAKENHURST
18 MAY 2004

INVESTIGATION REPORT

This report was written by the Prison Service under the direction of the Prisons and Probation Ombudsman.

15 November 2004

CONTENTS

1. INTRODUCTION

1.1 We would like to offer our condolences to the family of the man who died in custody at HMP Blakenhurst on 18 May 2004. The circumstances surrounding his imprisonment and death are particularly tragic and will have had a devastating effect on those close to him.

1.2 We are grateful to the Governor and staff of Blakenhurst prison for their help and co-operation with the investigation.

1.3 This investigation was commissioned by the Prisons and Probation Ombudsman, who assumed responsibility for investigating fatal incidents in prisons on 1 April 2004. As this was only two months before the man's death, it has been carried out largely by Prison Service staff, but under the direction of the Ombudsman.

1.4 The scope of this investigation is wider than that of one simply into a single death. The terms of reference include the fact that the man was the seventh death to occur since 31 March 2003. However, there were a further three deaths in the lower medical since July 2002 and after discussion with the Prison and Probation Ombudsman's office, we have also made reference to these deaths as there are common factors.

October 2004

2. PRISONER DETAILS

Age	30
Offence	Murder x 3 Offences committed 24 December 2003
Custodial status	Remanded by Walsall Magistrates, committed to Wolverhampton Crown Court
Received into custody:	9 January 2004
Time of Death:	11:53, Tuesday 18 May 2004
Place of Death	Cell 7, Lower Medical Centre
Method:	Hanging from bedsheet fixed to hatch in door

3. TERMS OF REFERENCE

1. The Ombudsman will investigate the circumstances of the deaths of the following categories of person:

- Prisoners (including persons held in young offender institutions). This includes persons temporarily absent from the establishment but still in custody (for example, under escort, at court or in hospital). It excludes persons released from custody, whether temporarily or permanently. However, the Ombudsman will have discretion to investigate, to the extent appropriate, cases that raise issues about the care provided by the prison.
- Residents of National Probation Service approved premises (including voluntary residents).
- Residents of immigration detention accommodation and persons under Immigration Service managed escort.

2. The Ombudsman will act on notification of a death from the relevant Service. The Ombudsman will decide on the extent of investigation required depending on the circumstances of the death. For the purposes of the investigation, the Ombudsman's remit will include all relevant matters for which the Prison Service, the National Probation Service (including area boards) and the Immigration Service are responsible, or would be responsible if not contracted for elsewhere by the Home Secretary or area boards. It will therefore include services commissioned by the Home Secretary from outside the public sector.

3. The aims of the Ombudsman's investigation will be to:

- Establish the circumstances and events surrounding the death, especially as regards management of the individual by the relevant Service or Services, but including relevant outside factors.
- Examine whether any change in operational methods, policy, practice or management arrangements would help prevent a recurrence.
- In conjunction with the NHS where appropriate, examine relevant health issues and assess clinical care.
- Provide explanations and insight for the bereaved relatives.
- Assist the Coroner's inquest in achieving fulfilment of the investigative obligation arising under article 2 of the European Convention on Human Rights, by ensuring as far as possible that the full facts are brought to light and any relevant failing is exposed, any commendable action or practice is identified, and any lessons from the death are learned.

4. Within that framework, the Ombudsman will set terms of reference for each investigation, which may vary according to the circumstances of the case, and may include other deaths of the categories of person specified in paragraph 1 where a common factor is suggested.

Clinical Issues

5. The Ombudsman will be responsible for investigating clinical issues relevant to the death where the healthcare services were commissioned by the Prison Service (until March 2006), by a contractually managed prison or by IND. The Ombudsman will obtain clinical advice as necessary, and will make efforts to involve the local Primary Care Trust (in Wales, the Local Health Board) in the investigation. Where the healthcare services were commissioned by the NHS, the NHS will have the lead responsibility for investigating clinical issues under their existing procedures. The Ombudsman will ensure as far as possible that the Ombudsman's investigation dovetails with that of the NHS.

Other Investigations

6. Investigation by the police will take precedence over the Ombudsman's investigation. If at any time subsequently the Ombudsman forms the view that a criminal investigation should be undertaken, the Ombudsman will alert the police. If at any time the Ombudsman forms the view that a disciplinary investigation should be undertaken by the relevant Service, the Ombudsman will alert the relevant Service. If at any time findings emerge from the Ombudsman's investigation which the Ombudsman considers require immediate action by the relevant Service, the Ombudsman will alert the relevant Service to those findings.

7. The Ombudsman and the Inspectorates of Prisons and Probation will work together to ensure that relevant knowledge and expertise is shared, especially in relation to conditions for prisoners and detainees generally and judgements about professional probation issues.

Disclosure of Information

8. Information obtained will be disclosed to the extent necessary to fulfil the aims of the investigation and report, including any follow-up of recommendations, unless the Ombudsman considers that it would be unlawful, or that on balance it would be against the public interest to disclose particular information (for example, in exceptional circumstances of the kind listed in the relevant paragraph of the terms of reference for complaints). For that purpose, the Ombudsman will be able to share information with specialist advisors and with other investigating bodies, such as the NHS and social services. Before the inquest, the Ombudsman will seek the Coroner's advice regarding disclosure. The Ombudsman will liaise with the police regarding any ongoing criminal investigation.

Reports of Investigations

9. The Ombudsman will produce a written report of each investigation which, following consultation with the Coroner where appropriate, the Ombudsman will send to the relevant Service, the Coroner, the family of the deceased and any other persons identified by the Coroner as properly interested persons. The report may include recommendations to the relevant Service and the responses to those recommendations.

10. The Ombudsman will send a draft of the report in advance to the relevant Service, to allow the Service to respond to recommendations and draw attention to any factual inaccuracies or omissions or material that they consider should not be disclosed, and to allow any identifiable staff subject to criticism an opportunity to make representations. The Ombudsman will have discretion to send a draft of the report, in whole or part, in advance to any of the other parties referred to in paragraph 9.

Review of Reports

11. The Ombudsman will be able to review the report of an investigation, make further enquiries, and issue a further report and recommendations if the Ombudsman considers it necessary to do so in the light of subsequent information or representations, in particular following the inquest. The Ombudsman will send a proposed published report to the parties referred to in paragraph 9, the relevant Inspectorate and the Home Secretary (or appropriate representative). If the proposed published report is to be issued before the inquest, the Ombudsman will seek the consent of the Coroner to do so. The Ombudsman will liaise with the police regarding any ongoing criminal investigation.

Publication of Reports

12. Taking into account any views of the recipients of the proposed published report regarding publication, and the legal position on data protection and privacy laws, the Ombudsman will publish the report on the Ombudsman's website.

Follow-up of Recommendations

13. The relevant Service will provide the Ombudsman with a response indicating the steps to be taken by the Service within set timeframes to deal with the Ombudsman's recommendations. Where that response has not been included in the Ombudsman's report, the Ombudsman may, after consulting the Service as to its suitability, append it to the report at any stage.

Annual, Other and Special Reports

14. The Ombudsman may present selected summaries from the year's reports in the Ombudsman's Annual Report to the Home Secretary, which the Home Secretary will lay before Parliament. The Ombudsman may also publish material from published reports in other reports.

15. If the Ombudsman considers that the public interest so requires, the Ombudsman may make a special report to the Home Secretary, which the Home Secretary will lay before Parliament.

ANNEX

REPORTING PROCEDURE

1. The Ombudsman completes the investigation.
2. The Ombudsman sends a draft report (including background documents) to the relevant Service.
3. The Service respond within 28 days. The response:

(a) Draws attention to any factual inaccuracies or omissions;
(b) Draws attention to any material the Service consider should not be disclosed;
(c) Includes any comments from identifiable staff criticised in the draft;
(d) May include a response to any recommendations in a form suitable for inclusion in the report. (Alternatively, such a response may be provided to the Ombudsman later in the process, within an agreed timeframe.)

4. If the Ombudsman considers it necessary (for example, to check other points of factual accuracy or allow other parties an opportunity to respond to findings), the Ombudsman sends the draft in whole or part to one or more of the other parties. (In some cases that could be done simultaneously with step 2, but the need to get point 3 (b) cleared with the Service first may make a consecutive process preferable.)
5. The Ombudsman completes the report and consults the Coroner (and the police if criminal investigation is ongoing) about any disclosure issues, interested parties, and timing.
6. The Ombudsman sends the report to the relevant Service, the Coroner, the family of the deceased, and any other persons identified by the Coroner as properly interested persons. At this stage, the report will include disclosable background documents.
7. If necessary in the light of any further information or representations (for example, if significant new evidence emerges at the inquest), the Ombudsman may review the report, make further enquiries, and complete a revised report. If necessary, the revised report goes through steps 2, 3 and 4.
8. The Ombudsman issues a proposed published report to the parties at step 6, the relevant Inspectorate and the Home Secretary (or appropriate representative). The proposed published report will not include background documents. The proposed published report will be anonymised so as to exclude the names of individuals (although as far as possible with regard to legal obligations of privacy and data protection, job titles and names of establishments will be retained). Other sensitive information in the report may need to be removed or summarised before the report is published. The Ombudsman notifies the recipients of the intention to publish the report on the Ombudsman's website after 28 days, subject to any objections they may make. If the proposed published report is to be issued before the inquest, the Ombudsman will seek the consent of the Coroner to do so.
9. The Ombudsman publishes the report on the website. (Hard copies will be available on request.) If objections are made to publication, the Ombudsman will decide whether full, limited or no publication should proceed, seeking legal advice if necessary.
10. Where the Service have produced a response to recommendations which has not been included in the report, the Ombudsman may, after consulting the Service as to its suitability, append that to the report at any stage.
11. The Ombudsman may present selected summaries from the year's reports in the Ombudsman's Annual Report to the Home Secretary, which the Home Secretary will lay before Parliament. The Ombudsman may also publish material from published reports in other reports.

If the Ombudsman considers that the public interest so requires, the Ombudsman may make a special report to the Home Secretary, which the Home Secretary will lay before Parliament. In that case, steps 8 to 11 may be modified.

Any part of the procedure may be modified to take account of the needs of the inquest and of any criminal investigation/proceedings.

The Ombudsman will have discretion to modify the procedure to suit the special needs of particular cases.

4. INVESTIGATION PROCESS

4.1 The investigation team started at Blakenhurst on Tuesday 25 May. We met the Governor and senior management team, and representatives of the POA and the Independent Monitoring Board. We explained the process of the Ombudsman's investigation and its terms of reference.

4.2 We visited the cell on 25 May. It was still sealed, although the police had taken away most of the man's possessions. The cell had two beds, fixed to the floor, a locker, which was broken, and a television. There was a toilet and a washbasin against the wall nearest the door. The windows were fixed shut, but there was a ventilation mesh between them. We considered the cell was dirty and that the unit generally was badly in need of redecoration. The Deputy Governor told us later that the decision to redecorate had been taken many months ago, but complexities with finance and procurement had delayed this considerably. While we were in the process of interviewing staff in following weeks we saw that the redecoration took place.

4.3 We also met a Detective Sergeant fromWest Mercia Police on 25 May, who told us the stage he had reached in his investigation, which had paused for forensic analysis of the ligature. He had not, at that time, concluded interviewing the staff. He gave us a copy of the video from Lower Medical on 18 May, but the police had seized all original documents on 18 May. This is contrary to national guidance, and caused us some problems due to the quality of some photocopies, but is apparently standard practice with West Mercia constabulary.

4.4 We began interviewing staff on 26 May. Where health care professionals were interviewed, the Director of Clinical Services and Nursing Services from Worcestershire Mental Health Partnership NHS Trust was also involved. On 8 June we interviewed those prisoners still in Lower Medical who were prepared to speak to us. Unfortunately two of the prisoners who were in cells adjacent to the man who died refused to be interviewed. We continued interviewing staff and the prison Listeners through June. One of the investigators attended the multi disciplinary team meetings.

4.5 A key witness, a prisoner in lower medical – who had allegedly bullied the man who died - could not be interviewed, initially because he had not been interviewed by the police and then because he was unfit. The outcome of the police enquiries is that a file has been prepared for submission to the Crown Prosecution Service and a decision is likely to be made at the end of February on whether charges are brought against the prisoner. However, to avoid further delay, this report is being submitted while there remains doubt about whether or not the prisoner was involved in the death of the man who is the focus of this report. However, we believe that the findings, conclusion and recommendations remain relevant.

5. ESTABLISHMENT BACKGROUND

HM Prison Blakenhurst is located on the outskirts of Redditch in Worcestershire. It is a category B local prison, serving a number of courts in the West Midlands area. It opened in 1993, and up to spring 2001 was operated by UKDS under a contract. In 2001 after a market testing exercise it was put under the control of HM Prison Service. At that time a number of staff who had been employed by UKDS in Blakenhurst transferred to work for the Prison Service, though most of the senior management came from elsewhere in the Prison Service. It is managed under a Service Level Agreement (SLA), against which performance is closely watched by a Monitor appointed by the Home Office. A number of staff interviewed stressed the differences that there were in managing an SLA prison against one that had not been market tested.

On 18 May 2004 it had a roll of 876 adult males, held mainly on four identical houseblocks. Each houseblock has three spurs with cells on three levels. Most prisoners are held in double cells. Houseblock 2 has two spurs for new prisoners on induction, and a third spur known as "Houseblock 5" which is a vulnerable prisoners unit. Roughly a third of the population are unsentenced, and generally sentenced and unsentenced prisoners are mixed. Half the population are employed in work or education. On 18 May there were 21 open F2052SH books.

During the time of our investigation a major construction and recruitment programme was under way to expand the prison to house a total of 1050 prisoners. A number of the staff who came into contact with the man who died were newly recruited, but otherwise this expansion project did not have a bearing on his treatment.

6. HEALTH CARE IN BLAKENHURST

Since it opened, health services in Blakenhurst have been contracted out to local NHS providers. This was the position both while it was a private prison and when it transferred to the HM Prison Service in 2001.

The health care centre was managed by a Senior Nurse Manager who had been at Blakenhurst since August 2001. She has a wide range of experience in prison health care. Primary Care was provided by Worcestershire NHS Primary Care Trust, which employed a team of Registered General Nurses, Registered Mental Nurses and Health Care Assistants (an unqualified auxiliary grade). The team also covered Hewell Grange, an open prison on the same site, with a part-time nurse 7.5 hours a week. The Reaside Clinic, a medium-secure unit in south Birmingham, provided psychiatric services through visiting specialists.

The target staffing figures were the health care manager, two G Grade nursing posts, two F Grade nursing posts, 14 E Grade nursing and five health care assistants. Although the primary care and mental health strands had separate requirements, the nursing staff at that time were working as a single team within one staff group. This meant that although there were staffing levels that they worked towards, there was not a predictable mix of RGNs and RMNs that would be on duty each day. We saw the staffing detail for the week that the man died. This seemed to aggregate all health care staff except for the Senior Nurse Manager, to arrive at the staffing levels for the day. This also included nights and weekend cover. Given that it was stressed by some staff on interview that Blakenhurst had serious problems in dealing with the mental health problems of some of their prisoners, we felt that a more predictable attendance pattern for the RMNs would have been helpful.

The work of the healthcare was divided into primary care, which was based in the upstairs part of the health care centre known as "Upper medical" and an inpatients unit on the ground floor known as "Lower medical". The primary care strand dealt with screening on reception, daily treatments, and doctor's and other clinics.

Lower Medical

The in-patient unit at Blakenhurst is referred to as Lower Medical. It has 22 cells in use, and on 18 May it had a roll of 13. In the week prior the roll had ranged between 13 and 16. The cells have a variety of accommodation; some have two fixed beds, some have a single King's Fund bed, and some have a high-backed bed.

The Lower Medical unit is shaped like a letter T. It comprises cells along a long corridor, which is bisected half way along by a shorter corridor. There are two association rooms (one of which used to be a six-bedded ward), offices and consulting rooms along the shorter corridor. When association was running, most staff and prisoners would be in the shorter corridor. Most of the living accommodation is on the right-hand spur, cells 1 to 12, as the special cells were out of use and had become stores. We were told by the Deputy Governor and Health Care Manager that despite there being two beds in some cells, they were never used for shared occupancy. This, they said, was because there were no privacy screens to shield the toilet from the other occupant. As such, the maximum capacity of the unit was 22. The Senior Nurse Manager told us that there were enough beds for everyone in Blakenhurst that met their admission criteria, as they "stick to admitting people that very clearly have clinical needs that we would be able to do

something with, that we would be able to find treatment for". However the Head of Operations manager with responsibility for health care, and former Safer Custody governor, did not think there was an adequate number of beds.

A small number of prisoners in the Lower Medical were marked on the roll-board in the office as "non medical". Another list showed them as ROSH – at risk of self-harm. One of these was on an F2052SH at the time of the man's death. He had also been involved in a number of protracted incidents at Blakenhurst and other prisons where he had climbed up bars, out of reach of staff, to make protests. We considered it significant that the lower medical was the only accommodation in Blakenhurst where it was not possible for him to climb.

There was a published regime and other correspondence illustrates the intention for this to be meaningful. The prisoners in Lower Medical that we interviewed described the regime there. They said that there was an education session once a week, when they made things. Quite often the healthcare department was short staffed, they said they remained locked up until more staff were on duty.

Accommodation, Lower Medical centre

Outside Gate

6 Two beds		5 Single
7 Two beds		4 Single
8 Single		3 two beds
9 Single		2 two beds
10 Single		1 two beds
11 Single (King's fund bed- KFB))		Store
12 Single (KFB)		Store
13 Single	→ Association rooms and offices	
14 Single		Bathroom
15 Single (KFB)		
16 Single (KFB)		Treatment room
17 Single (KFB)		
18 Two beds		24 Out of use special cell (store)
19 Single		23 Out of use special cell (store)
20 Single		22 Two block beds
21 Gated cell		Stairs up

The Senior Medical Officer has been at Blakenhurst for six years. Although he had the title of Senior Medical Officer, he described this as a misnomer as he was not part of the senior management team and did not have any management responsibilities. He told us he went to see patients in Lower Medical "three days of the week (…) sometimes more often but pretty reliably three days of the week, and seeing people there that were giving rise to concern or needed to see a doctor for some reason". Mental health referrals were made, but there had been some unpredictability in the past about when someone would be seen from Reaside. The amount of mental health input appeared to have improved in recent weeks because of the efforts of the prison Mental Health In-Reach Team psychiatrist, though the Senior Medical Officer said he felt they could do with a lot more.

There has been a clinical review by Worcestershire Mental Heath Partnership NHS Trust running parallel with this investigation. The report of that investigation is submitted with this one.

We have studied the relevant extract from the Service Level Agreement which sets out binding requirements on Blakenhurst's level of performance regarding Healthcare.

It states, referring to **General Practitioner** cover: (Section 1.3.9 (b)):

1. A General Practitioner (GP) will be available in the establishment at the following times:
   - 0800-2100 Monday to Friday.
   - 0900-1300 Saturdays.
   - 0900-1100 Sundays.
2. His duties will include but not be limited to :
   - Daily surgeries (Monday to Saturday).
   - Visiting prisoners in the segregation unit and hospital every day.
   - Assessments of new admissions within 24 hours of admission.

(……)

6. In addition to clinical duties, the lead GP will manage other aspects of Prison Medicine including (….) Management of Mentally Disordered Offenders. (……)

12. Prisoners requiring urgent psychiatric assessment or care will be seen within 48 hours. Non-urgent cases will be seen within two weeks. This accords with current NHS practice for the local area.

The section relating to **inpatients** (Section 1.3.9 (c)) states:

Prisoners who are inpatients will have access to a multi-disciplinary purposeful activity programme that is based on their individual health care action plan.

The environment will be therapeutically oriented and the emphasis will be on social interaction and support.

Prisoners will have up to 12.5 hours a day unlocked dependant on privilege level.

An occupational therapist will be appointed to deliver a programme of occupational therapy in the health care centre.

The Agreement Holder will provide further social and life skills and opportunities for improving skills in literacy and numeracy through outreach work with the Education Department.

..9 A Listener will be available 24 hours a day in the HCC whose role will be to support the in patients and provide a 'buddy' for patients considered at risk of self-harm.

Regarding specialist services, the SLA states (1.3.9.(e))

Psychiatrist

5. Reaside Clinic Birmingham under the provisions of the contract with Worcestershire NHS Trust will provide forensic psychiatric services.
6. A visiting psychiatric service will be delivered on site that will include a 48-hour response to emergencies. Psychiatric services will provide for the assessment, treatment, management and where appropriate the transfer of mentally disordered offenders to NHS inpatient facilities.

7. Previous Deaths at Blakenhurst

The following chart records all the deaths since 15.07.02.

Date	Name & age	Location	Time	Manner	F2052SH open	Mental Health treatment	Detox issues	Previous custody	Received	Custodial status/ offence
14.1.04	Mr A, 23	HB2 shared, cellmate absent	1425	Hanging from bunk	No	Yes	No	Yes	12.1.04	18 months, possession with intent to supply
30.11.03	Mr B, 62	HB1 shared, cellmate absent	1109	Hanging from window	No (several previous, last closed 8/03)	No	No	? No	24.12.01	6 years, wounding (ex-partner)
8.6.03	Mr C, 32	Lower medical, single cell	2245	Hanging from pictureboard	Yes	No (but saw psychologist)	No	? No	5.6.03	Remand, murder (girlfriend)
13.5.03	Mr D, 24	Lower medical, single cell	0015	Hanging from bedframe	Yes	Yes (psychology)	No	Yes	28.9.02	2 years, 1 month, taking and driving away
31.3.03	Mr E, 29	HB3 shared, cellmate absent	1720	Hanging from bunk	No (closed 18/2)	No	No	No	3.2.03	Trial, GBH
30.3.03	Mr F, 44	HB5 shared, cellmate absent	1220	Hanging from upended bed	No	No	No	No	13.2.02	Life – murder (his two children), sentenced 25/3.
13.9.02	Mr G, 44	Lower medical, single cell	0805	Hanging from bedframe	No (closed 2/8)	Yes Schizophrenic	No	Yes	12.6.02	Licence revoke, 3½ years, arson
13.8.02	Mr H, 49	Lower medical, single cell	1134	Hanging from bedframe	Yes	No, depression and schizophrenia untreated	Yes - alcohol	Yes	9.8.02	Unsentenced, arson
15.7.02	Mr I, 25	Lower medical, single cell	1015	Dehydration	No	No	Yes	No	4.7.02	1 year, driving offences

Each death prior to April 2004 has been investigated by a Governor from another prison who had been trained in such investigations. However each investigation process was carried out independently and in many cases overlapped, so that preceding investigation reports were not available to the teams following them. The following is a précis of the circumstances around the deaths of each prisoner.

Mr I

Mr I's death in July 2002 was not self-inflicted and is currently subject to a further police investigation. Although it happened in the Lower Medical, we do not propose to consider the recommendations from that report. They related primarily to clinical issues.

Mr H

Mr H was in the Lower Medical for alcohol withdrawal, and was the subject of an F2052SH when he hanged himself in August 2002. He had a history of depression, which was not being treated at the time, and had also been refusing food for several days. He had been placed in a single cell as it was local practice for prisoners undergoing alcohol detox to be in a cell on their own. That investigation made a number of

recommendations regarding healthcare and the management of suicidal prisoners in single cells.

Mr G
Mr G was found hanged in Lower Medical on the morning of 13 September 2002. He had been dead for several hours. A F2052SH had been closed on him on 2 August but he had not been regarded as posing a risk of self-harm at the time of his death. He was being treated for schizophrenia. The investigation made a number of recommendations regarding staff access to scissors or cut-down knives, managing prisoners with multiple drug or mental health issues, roll checks, contingency plans, staff training and access to previous medical records.

Mr F
Mr F died on 30 March 2003. He was found hanged from an upturned bed on Houseblock 5 (the vulnerable prisoners unit). He had been sentenced to life imprisonment five days earlier for the murder of his two sons. He had refused an offer to go to Lower Medical after being sentenced. He had been in a shared cell, but his cellmate had gone on a visit. The report recommendations related to the maintenance of F2052SH files and improving the quality of Lifer liaison officer work.

Mr E
Mr E hanged himself on Houseblock 3 in the afternoon of 31 March 2003 while his cellmate was at work. He had been the subject of a F2052SH which had been closed a month earlier. He had been discussing the death the previous day of Mr F with other prisoners. The Sikh Minister told the investigation team that he had asked for him to be sent to the chapel for a telephone call that afternoon, but he was not sent. That investigation team (which worked on the Mr F investigation at the same time) made the same recommendation about the maintenance of F2052SH files and also about prisoners going to the Chapel.

Mr D
Mr D hanged himself in the Lower Medical in the night of 12/13 May 2003. He was on a level 2 watch. Resuscitation was attempted but he died in outside hospital 30 minutes later. The investigation recommended that the Suicide Prevention policy be reviewed, that anti-ligature knives should be issued to all staff, that the cell call system be upgraded to record events, that the quality of F2052SH files should be improved, and that there should be a review of the staffing and accommodation of Lower Medical. They also recommended that consideration be given to taking the shoelaces of prisoners on level 2 observations.

Mr C
Charged with the murder of his girlfriend, Mr C hanged himself with a belt in the Lower Medical during the night of 8 June 2003, three days after coming into custody. He was on a F2052SH. The investigation recommended improvement in the F2052SH process, co-ordination of the action plans from previous death in custody reports, that belts should be taken away from suicidal prisoners, and that the establishment should seek opportunities to develop a better environment for suicidal prisoners.

Mr B
Mr B was 62, serving a six -year sentence for wounding his ex-partner. He had been in custody since late 2001. He had been subject to a number of previous F2052SHs, the last

being closed in August 2003. He had told a Listener a few days before his death that he felt suicidal, and the Listener told an officer, but no F2052SH was opened. He had problems with his legs and his poor personal hygiene led to conflict with his cellmate and staff on the day of his death. He was discovered hanging on HB1 on 30 November 2003, when his cellmate had been let out cleaning. The investigation recommendations strongly reflect those for Mr C (or vice versa, given that Mr B's report was submitted before that of Mr C).

Mr A
Mr A died two days after reception, on 14 January 2004. It was his first time in prison, and he was withdrawing from heroin. He was located in a shared cell on HB2, but his cellmate had gone to court. Staff were alerted at 14:00 when they noticed his cell call light was on. When they went to check, he was hanging from the wall cupboard. Attempts at resuscitation were unsuccessful and he was pronounced dead at 14:25. The cell call system at Blakenhurst does not log when a call is made. The recommendations asked again for a better cell call system, wider issuing of ligature knives, removal of the wall cupboards and more first aid training.

Some recommendations were repeated in a number of reports. We have reproduced the recommendations from the previous investigations verbatim below.

Mr H

- More shared cells should be available in the lower health care.
- The administration section of the health care should take steps to expedite retrieval of previous medical records.
- The health care unit should develop a formal detoxification protocol that specifies who is eligible for detoxification and under what circumstances, what regime(s) should be used, and what documentation is required.
- The role of health care staff should be clarified in the contingency plans
- The guidance in PSI 27/2001 (Use of unfurnished cells) should be incorporated into the suicide prevention strategy document
- The suicide prevention committee should review closed F2052SH at their meetings
- Where a prisoner at risk of self harm is placed in a single cell, other measures, such as level of observation or provision of a safer cell, should be considered to reduce the risk.
- The level of observation (1,2 or 3) should be clearly set out when a prisoner is considered at risk of self harm.
- An assessment should be undertaken by a manager and recorded in the F2052SH where the risk of self harm is balanced against other considerations and it is decided to place a prisoner in a single cell

- If observations are not to be recorded in F2052SHs in accordance with the current policy document, the policy should be revised; otherwise staff should be reminded of the frequency and management should check on this.

Mr G

- There is consideration of a review of the national policy that states resuscitation is always attempted unless rigor mortis has set in.
- The instructions on who, when and how roll checks are conducted are reissued, training given where necessary and auditable management checks are reinforced.
- There is consideration of a review of the protocols and systems used to manage prisoners with multiple issues including mental health and drug and alcohol misuse where attempted suicide or deliberate self-harm is and has been a concern but where there is a belief that the individual is not in immediate risk of suicide or self-harm. This review should include:

    1. Methods of assessment to identify risks;
    2. Training for staff in assessing risks at reception;
    3. Training for staff in assessing risk on a day to day basis;
    4. Training for staff in managing prisoners with multiple issues including mental illness;
    5. Methods of assessing the best location and activity programme for prisoners with multiple issues including mental illness;
    6. The resource implications of the above

- The instructions and protocols regarding the retrieval of previous medical records should be reviewed so as significantly to expedite this process and an action plan agreed with the Governor as to how and when this will take place.
- The Suicide Prevention team review training and quality control measures for the F2052SH process and agree an action plan with the Governor as to how and when this will take place.
- Instructions regarding the transfer of prisoners on overcrowding drafts are reviewed and an action plan is agreed with the Governor so as to prevent the transfer of prisoners with multiple issues like Mr G without proper consultation with relevant groups at HMP Blakenhurst and the receiving prison.
- The anti-bullying strategy in operation be reviewed to ensure it meets the needs of all prisoners and staff awareness of and training in how to prevent bullying includes all staff.
- The instructions for staff on duty at night in the Healthcare Centre are reviewed to ensure that they are clear, meet principle goals and have been communicated to all staff with additional training being given where necessary.
- The local contingency plans are reviewed to ensure that all staff are offered the same level of support and information about support where necessary offering training and guidance for those implementing the plans.
- The local contingency plans are reviewed to ensure follow up contact with next of kin takes place and is recorded where necessary offering training and guidance for those implementing the plans.

Mr F: Recommendations

1. F2052SH files

Blakenhurst should improve in the following areas:

a. Multi-disciplinary representation at reviews
b. Timing of reviews i.e. meet the deadlines
c. Support plans – one is required even when closing a file.

2. Life Sentence Liaison Officer
We were told that this was a 20-hour per week task. Given the small number of prisoners involved, we would have expected closer contact and better file notes than in the Wilson case. The post and post holder should be reviewed.

Mr E

1. F2052SH files
Blakenhurst should improve in the following areas:

a. Multi-disciplinary representation at reviews
b. Timing of reviews i.e. meet the deadlines
c. Support plans – one is required even when closing a file.

2. Attendance at Chapel
The Governor should meet with Houseblock managers and the Chaplain to resolve the apparent ongoing failure in communication.

Mr D

1. The Suicide Prevention Policy should be reviewed in the light of PSO 2700 ie intermittent supervision
2. Healthcare Centre staff must be reminded to maintain F2052SH files alongside Inmate Medical Records and treatment plans.
3. Anti-ligature knives should be issued to all staff (the new "fish" type is recommended by Safer Custody Group)
4. The Governor should press for a cell bell recording system which would (a) show when a prisoner has called for attention, (b) record staff observations on self-harm risks. Birmingham has such a system, as has Featherstone, where the risks of deaths in custody are far less. Level 2 prisoners are sometimes held on normal location when there is no video coverage.
5. The check of current F2052SH files must be more rigorous.
6. Healthcare Centre accommodation and staffing

Blakenhurst Healthcare staff are under a great deal of pressure – they take difficult and at risk prisoners from other gaols as well as their own. There is a case for more safer cells, possibly more staff. The Governor should consider these issues.

7. Shoelaces

The Governor should consider the removal of shoelaces from Level 2 prisoners. This is a question of balance. One must remember that sheets are readily available and one can easily borrow laces.

8. Code of Discipline Investigation

Whilst procedures on the last night were not carried out to perfection, there is insufficient failing to justify such an investigation or to involve the police.

Mr C

Relating to Death

- No separate disciplinary investigation should be undertaken against any member of staff

Other Issues

- F2052SH procedures require review. Guidelines within the document should be followed at every stage including: the prisoner being seen by the doctor within 24 hours; 72 hour reviews; adequate support plans being completed and multi-disciplinary case reviews.
- A co-ordinated system of management checks on F2052SH documentation needs to be implemented.
- Staff require further training in F2052SH procedures including the quality of entries.
- Priority should be given to the co-ordination of action plans for this and previous Death in Custody reports.
- Action points from Death in Custody reports should be a standing agenda (sic) for Suicide Prevention Strategy meeting.
- The establishment should include in its policy that potentially suicidal prisoners should not be left in possession of belts or similar items.
- The establishment should seek opportunities to develop a supportive environment for potentially suicidal prisoners. Although procedures are observed, there should be an atmosphere of support and care throughout the establishment.

Mr B

Relating to death:

- Local contingency plans for death in custody, particularly first on scene arrangements, should be reviewed as soon as practical.
- No separate disciplinary investigation should be undertaken against any member of staff.

Other Issues

- Procedures for completion of medical documentation such as F2169S, IMR, F213 injury report forms and medical treatment cards require review.
- F2052SH procedures require urgent review. The guidelines in the document should be followed at every stage including: prisoner being

seen by a Doctor within 24 hours, 72 hour reviews; adequate support plans being completed; multi-disciplinary case reviews.

- A co-ordinated system of management checks on F2052SH documentation needs to be implemented.
- Staff require further training in F2052SH procedures.
- A training needs analysis is required, paying particular attention to first on scene, first aid and suicide prevention.
- Priority should be given to the co-ordination and implementation of previous Death in Custody action plans. Recommendations from this report need to be incorporated with previous action plans and prompt, strategic action needs to be followed through in all cases.
- Consolidated points from the Death in Custody action plans should form a standing agenda item at the local Suicide Prevention Strategy meeting.
- The system for cell sharing risk assessments requires prompt review.
- Whilst not related to the death, funding should be sought to purchase a cell call bell monitoring system.
- The role of the Care Team following such an incident requires review.
- A staff de-brief should be scheduled as soon as possible following such incidents.

Mr A

Issues Directly Related to the Death

- The fact that the cell call bell had been pressed by Mr A before his death may or may not have had a direct bearing on the incident. We recommend that the Governor should press for a cell bell recording system which would (a) show when a prisoner has called for attention, (b) record when staff have cleared the cell call bell on the outside of the cell door, (c) record staff observations on self harm risks. Birmingham has such a system, as has Featherstone.

In the meantime staff must be reminded of the importance of answering cell call bells immediately.

Other Issues

- Anti-ligature knives have been issued to some staff. They should be issued to all staff.
- The wall cupboards in cells within the Induction Unit should be removed and replaced with Prison Service floor standing wardrobes/cupboards.
- First Aid training for staff should be brought up to date to ensure there are trained staff on duty at all times on all units.

8. PRISONER BACKGROUND

8.1 The man who died was remanded in custody on 9 Jan 2004 at Walsall Magistrates Court, charged with the murders of his partner and their two daughters on 24 December 2003. He had a broken leg and a stab wound to his abdomen, after he had crashed his car in what was an apparent attempt to kill himself, after he had apparently committed the offences.

8.2 The Community Psychiatric Nurse from Telford Mental Services opened a F2052SH on 9 January 2004 at 1030 hours. Level of observation was to be level 2, 5 times per hour. This remained open until 11 March. The man said to Premier Prison Services staff that he intended to kill himself, and would not serve a sentence. On reception at Blakenhurst later that day, he was initially signed up for segregation under Prison Rule 45 for his own protection, because of the nature of the charges he was facing. However he was admitted to the hospital inpatients unit (lower medical), both because of his broken leg and for mental health assessment. The man saw the Deputy Governor at 19.00 hours, and said he could not understand why anyone would be speaking to him after what he had done. He was seen for health screening and it was noted in his F2052SH that he should be on a level two watch.

8.3 He said he had not been in prison since 1989, when he had been in Brockhill (then a Young Offenders Institution) facing a charge of theft.

8.4 On 10 January he requested a lethal injection. Because of concerns that he would harm himself, on 10 January he was placed on a constant watch during the night in a gated cell, and with close observations during the day. His Cell Sharing Risk Assessment was not fully completed. The original screening assessed that he was low risk, and the Health Care screener considered they had too little information to form an opinion (that assessment was subsequently reviewed on 16 April). When he was assessed for type of accommodation on his F2052SH, he was being admitted to health care marked for single cell. Healthcare staff described his mood as low, he did not want to mix with others and he would not eat or drink properly.

8.5 On 12 January he was interviewed in Lower Medical by the child protection officer, because his offences were against children. He told her that he was not concerned as the only visits he would have would be from his father and brother. That day he also went to an appointment at hospital for follow up treatment for the injuries sustained in the car accident.

8.6 The Inmate Medical Record records a consultation on 15 January by a Specialist Registrar (Psychiatrist) who recommended a possible transfer to a high security hospital but with an initial referral to Reaside clinic. It would appear from the documentation that the man who died was assessed by the Community Psychiatric Nurse and another psychiatrist sometime during his admission to the hospital, but the date for this is not clear. On 19 January he went to court again, and was remanded to stand trial at Wolverhampton Crown Court. On 21 January he was reviewed by a Senior House Officer and Senior Nurse from the Reaside

clinic.

8.7 His F2052SH was also reviewed on 21 January. He was still having difficulty coming to terms with what had happened, but he was eating and sleeping normally. He had been moved down to a level three watch. On 23 January he talked at length about his daughters, saying he could not carry on without them. Furthermore, he had refused to take his medication on 25 January, and the F2052SH shows this happened on a regular basis. Consequently, there was a further F2052SH case review on 26 January. He said that he would attempt to take his life, and could not cope. The review concluded with him returning to level two supervision.

8.8 On 27 January he became angry at the decision to discharge him from lower medical. He stated "no one is helping him", and also spoke about killing himself. On 28 January he moved from the health care centre to Houseblock 5, the vulnerable prisoners unit. In his discharge report, the Senior Medical Officer wrote that he thought he should remain on a self-harm watch indefinitely. The man was put into a double cell on Houseblock 5 with another prisoner. He was seen talking to other prisoners on the unit, asking how he could hang himself. In his F2052SH in 3 February he said he did not think he could take his own life.

8.9 The funeral of his partner and children was held on 7 February. He went to the prison chapel on that day at 10:40, with one of the Chaplains. The level of watch was raised from level 3 to level 2 but this was for a short period only.

8.10 On 12 February at the weekly case review he was tearful, upset and talked about killing himself. He wanted to be reunited with his wife and daughters. Following the case review, prison In-reach workers spent an hour with him. He appeared very distressed, describing his late wife as a pagan witch who played "mind games" with her family. He claimed that both he and his wife took cannabis, cocaine and amphetamines. It was agreed he would be provided with 30 minutes bereavement counselling each day. On 16 February it was recorded in his F2052SH that he was contrite about what he is said to have done and wanted to be baptised. He had a further hospital appointment on 17 February.

8.11 At his case review on 19 February he said that he said he no longer felt suicidal, and was incapable of killing himself, even though he did not have the will to live. He requested more contact with Chaplaincy. The next day he asked for listeners as he wanted to talk. On 20 February, he saw the Clinical Psychologist. However on 24 February, it was recorded in the F2052SH that his cellmate told staff he said he was still intent on killing himself, but did not know how. On 26 February, his F2052SH was reviewed, and although he was tearful, he stated he was no longer suicidal. The level 3 watch was continued, and he was offered listener support if required. He was identified as requiring further support with bereavement.

8.12 On 2 March he was involved in an incident in visits where it was thought he had been passed some drugs. He was removed to the segregation unit but returned to HB5 in the evening. He was adjudicated upon on 5 March, and given a caution. He was placed on non-contact visits until June. On 3 March, a fellow prisoner, advised staff that the man at the centre of this investigation was asking other

prisoners for drugs so he could overdose. There should have been a scheduled review on 4 March 2004 but this did not take place. This was identified by the night orderly officers checklist every night between 7 March 2004 and 10 March 2004 but no special review took place.

8.13 On 5 March there is an entry in F2052SH made by the lifer officer; "appears in better spirits. Feels better and is looking forward to continuing medical/psychiatric nurse contact." The man's cell mate, reported that during the early hours of 7 March he noticed that the man's breathing pattern was different to previously. The IMR confirmed that he was unlocked by the Orderly Officer and one nurse. Having assessed him as safe to leave, he remained in the cell overnight. However, he became abusive to his cell mate and was unhappy that he had pressed the bell. Consequently, the cell mate requested to share with a different prisoner.

8.14 On 9 March the Chaplain, who accompanied the man to the chapel on the 7 February, recorded that the man still could not come to terms with what had happened and why he was in Blakenhurst. On 10 March the IMR records that he was feeling low and depressed, and having nightmares. He said he was not sure why he was in prison, and finding it difficult to cope. He commenced a course of anti-depressant medication.

8.15 His first F2052SH was reviewed again on 11 March by two Chaplains, an officer and a senior officer. He had been working in industries for three weeks, and said he no longer felt suicidal. No member of the healthcare team was present and his conversations the previous day do not appear to have been communicated. Consequently, the F2052SH was closed. As a support plan, the review concluded he should receive continued support from the chaplaincy and prison in-reach, and bereavement counselling should be arranged. It does not appear from the interviews conducted with chaplaincy staff that he ever received any professional bereavement counselling.

8.16 He had a review at the RMN clinic on 6 April. He was talking about pagan influences throughout his life. He spoke about his offences and accepted he probably committed the crime but he did it to "save them from the hurt and hypnotic influence and mind control… and he had sent them to a better place". Also said, "it would be against Christian teaching to kill himself but if he could be executed he would join his family".

8.17 On 14 April he declined association. He said that other prisoners would kill him. 15 April was the anniversary of one of his daughter's birthday. On 16 April he was given a mental health assessment by the prison psychiatrist, who found the man to be actively psychotic and obsessed with witchcraft. She described him as having "an extensive history of substance abuse, …. very deep seated persecutory ideas and very bizarre idealism relating to witchcraft and Satanism, which he felt was prevalent in his home community and he extended that to include the prison as well." She wanted a doctor from Reaside to see him and, if he thought it appropriate, to transfer him to the Reaside Clinic. This was not actioned. It was recorded in his F2052A that he had been considered a high risk of danger to other prisoners due to his unpredictability. His cell sharing risk assessment was reviewed, and he was kept in a single cell from this point on. On 20 April he was

unable to attend a clinic due to staff shortages. Although the documentation does not specifically identify that this was a Mental Health Clinic, this has been identified by nursing staff as the most frequently cancelled clinic.

8.18 On 23 April he was seen for a report by the forensic psychiatrist (Reaside Clinic) who assessed he was experiencing auditory hallucinations. He suggested that if possible the man should be readmitted to the healthcare centre for further observation, and he would liaise with the doctor at Reaside. The man remained on house block 5 and the same day he self-harmed by making cuts to his left arm, which he said, was to relieve stress. Contrary to procedures, the F2052SH was not reopened.

8.19 On 26 April two laces were found by an Officer, knotted together in his cell with a loop at either end. He said that it was for hanging bottles outside the cell window to keep them cool. The laces were taken from him, as they could have been used as a weapon as well as a ligature for self-harm. He denied any suicidal thoughts, and so staff did not open a F2052SH.

8.20 He started to express bizarre thoughts in his telephone calls to his family. On one occasion he referred to giraffe, elephants and apes being in the gymnasium and being out playing golf.

8.21 On 6 May he damaged his television. He told an Officer it was because his father was talking to him through the television. He was not placed on report due to his mental state. On 7 May his Olanzopine was increased as he was found to be showing psychotic symptoms.

8.22 On 8 May his behaviour deteriorated. He had cut his forearm, and was found with a noose in his locker. A second F2052SH was opened by an Officer on Houseblock 5. He was placed on a level 3 watch. However in the F2052SH there was no nursing assessment, and comments by a doctor indicate "same level as before". On 9 May he was displaying bizarre behaviour, which in the F2052SH the Officer considered was manipulative.

9. EVENTS LEADING UP TO THE INCIDENT

9.1 On 10 May 2004 he told his family that "when I went mad, I thought Richard and Judy were talking to me through the television". He said he didn't know what he was doing; he thought he was protecting his family. He told them that he had been headbutting the wall. Staff had observed him banging his head against the wall and complaining of hearing voices. Two Officers went to see him in Houseblock 5 because they were concerned about his mental state. At 16:35 he was moved back to Lower Medical.

9.2 11 May was his 30th birthday. On that day the man went to a hospital appointment to have his leg examined. He went with three officers. The escort risk assessment was endorsed for two officers; the third was a newly recruited officer, who went purely as a learning experience. The Officer who went to collect the man said he was talking to himself, and he asked "is it to get a

parachute so I can jump out of the trees?" At the time of interviewing this Officer who was also in charge of the escort, we had a poor copy of the Prisoner Escort Record (PER form) and the risk assessment had not yet been provided. The former did not show that it had been identified that the man was subject to an F2052SH and the Officer stated that he was not aware that the man presented a self-harm risk. However, a clearer version of the PER form and the risk assessment supplied later clearly shows that he was subject to a F2052SH. Despite being recorded on the risk assessment and PER form, his F2052SH did not go with him. Consequently, there are no entries made between 09:00 and 14:40, and those either side are made by nurses. The escort staff remarked in interview that the man expressed bizarre thoughts, but this was not recorded on the PER form or in his F2052SH.

9.3 The scheduled 72 hour review of the F2052SH was not completed on 11 May 2004, nor was this identified and corrected before his death. Consequently, there was no check that the initial action suggested when the F2052SH was opened was followed through. This included support from Chaplaincy and Listeners. A Listener saw the man who died on a regular basis, but there is no evidence in his F2052SH that he had any meaningful Chaplaincy contact. Three others from the Chaplaincy had contact with him earlier in his sentence, but had minimal contact with him when he was on lower medical. The other suggestion that the man should be included in domestic work does not appear to have been followed through.

9.4 On 13 May he was seen by the Senior Community Psychiatrist from the Reaside Clinic. The outcome of this was for the man to be discussed at the next clinical team meeting, with a view to referral to Reaside. On the same day the man was assessed by the forensic psychiatrist from Reaside who recommended transfer to hospital for assessment and treatment under section 47 of the Mental Health Act. Due to nature of his alleged offences and the incidents regarding his mental health, it was felt maximum security conditions may be appropriate. The forensic psychiatrist would liaise with the Senior Community Psychiatrist and doctor at Reaside. He was again observed as banging his head, and complaining of hearing voices.

9.5 He had a legal visit on 14 May. A member of staff (Operational Support Grade), who supervised him, did not notice anything unusual about his behaviour. He declined association on 14 May, as he felt everyone was going to kill him. The Health Care Assistant also observed him banging his head around this time. However, when interviewed she said that she was not convinced his behaviour was genuine, as she would observe him behaving normally and interacting with other prisoners on association, but then say something inappropriate when staff approached. A nurse at the prison also observed that when she was on duty on 15 May, the man was acting bizarrely, saying "they were going to kill (him)", and kept slapping his own face, to get rid, he said, of the demons. Although he had money in his account to spend on 16 May, he did not order anything from the canteen. A Chaplain attempted to talk to him. He said that he was fine but declined to talk. The Chaplain told him that he would come back later in the week.

9.6 On the morning of 17 May 2004 he complained to his family by phone that he felt empty and was "round the bend". He was encouraged to go to the workshops. The man said that he had been told that he was not ready for trial. He telephoned again in the middle of the afternoon. He continued to talk about being mad. His last comment to his family was "I'll phone you tomorrow or something".

9.7 On the night of 17 May there were five prisoners subject to F2052SH in Lower Medical, of which the man who died and the prisoner who allegedly bullied him were on level 3 observations, so deemed at the lowest risk. Two of the five prisoners were on constant watch and one other had been subject to a constant watch. One of the two on constant watch was considered to be a greater risk, so he was moved into the gated cell. As there was only one gated cell but two prisoners on constant watch, one would be held in the cell next to the gated cell to enable close observation when the cell door was shut.

9.8 Healthcare staff were clearly under great pressure due to the number of prisoners requiring a high level of support. Most nursing staff feel that the man who died was at a lower risk of self harm than the other prisoners above.

10. THE INCIDENT

Prisoner cell locations 18 May 2004

6 Prisoner		5 Prisoner
7 The man who died		4
8 The prisoner who allegedly bullied the man		3 Prisoner
9 Prisoner	Officer 1	2
10 Prisoner		1 Prisoner that had been subject to constant watch
11		Store
12 Prisoner		Store
13	→ Association rooms and offices	
14		Bathroom
15		
16		Treatment room
17 Prisoner		
18		24 Out of use cell (store)
19 Prisoner on Constant Watch		23 Out of use cell (store)
20 Prisoner	Officer 2	22
21 Prisoner on Constant Watch		Stairs up

10.1 There is some uncertainty as to which cell some of the prisoners were in; the locations above are taken from the unit cell movements book. Where cell numbers are noted on the police statements, they accord with the above.

10.2 At about 09:00 on 18 May the man who died was up, and asked the Health Care Assistant for a shower. She said his mood was good, and was surprised he was up, as they normally had to wake him.

10.3 The prisoner in cell 12 told us he had been sitting in the pool room with the prisoner in cell 10 (who declined to be interviewed) when the man who died came in to talk to them. They were talking about how fed up they were with the number of suicide attempts that were happening. The prisoner in cell 12 said that he thought a prisoner had been bullying the man who died, because he know about his alleged offences, and he was taking things from him. The prisoner in cell 12 and prisoner in cell 10 went out on exercise at about 10:55 hrs, leaving the man who died smoking in the pool room.

10.4 A number of staff were around the Lower Medical on the morning of 18 May. In addition to the nursing staff, there were uniformed staff supervising constant watches. At about 11:00 the Head of Operations came in with the Senior Nurse Manager at the Health Care Centre, and the chaplain, to review, the prisoner in cell 21, who had been placed on a constant watch the night before.

10.5 The prisoner who allegedly bullied the man who died had been pressing the Health Care Assistant to have his F2052SH reviewed, as he wanted the file to be

closed and to be transferred out. She was sat in the office, and told him to go and talk to the man who died, who she referred to as his mate. He went to his cell, and came back to her saying the prisoner in cell 9 had "cut up really bad".

10.6 A nurse had been in cell 5, opposite to the man who died. She and an officer went to the man's cell. There was a ligature made from a torn bedsheet, and the knot at one end had been slid under the hinges of the door hatch, which was open. The other end was tied tightly around the man's neck, and he was hanging on the other side of the door. They pushed their way into the cell and the nurse cut the ligature.

10.7 The Senior Nurse Manager could not get into the cell initially as the other staff were behind the door, but she entered when they moved him and checked for vital signs. There were none, so she began chest compressions while the nurse who first found the man worked on his airway. She called for the defibrillator, and the doctor.

10.8 A Chaplain, also the Safer Custody Manager at the prison, sat with the prisoner in cell 21 to watch him, to allow the officer who had been supervising him, to go to the scene.

10.9 The Senior Medical Officer for the prison stated in the Inmate Medical Record that he saw him at 1130 on 18 May. He came down from Upper Medical, having been told (wrongly) that he needed to come and attend urgently to the prisoner in cell 9. He maintained CPR, but despite their efforts there was no register on the ECG, and they could not resuscitate him. He was pronounced dead by the Senior Medical Officer at 1153.

10.10 A post mortem examination identified the cause of death as hanging.

10.11 Following the incident the police seized the video evidence from the camera at he end of the lower medical landing (above cell 21). Examination of footage shows that the prisoner who allegedly bullied the man who died went into the man's cell where he remained for one minute before going to the association room. At 11.33 he stood in the middle of the landing and looked up and down. He walked to the far end, checked cell 5 and walked back to the offices. At 11.35 he walked past the constant watch officer who was observing the prisoner in cell 1, who had been subject to constant watch, and went to cell 7. The tape shows the prisoner who allegedly bullied the man who died bent over, apparently facing the cell hatch and then jerking upwards three times before reaching in through the hatch. He then walked away from the door. The rest of the tape shows the staff who entered the cell in an attempt to resuscitate the man.

When interviewed by police later on 18 May 2004, the prisoner who had been by the cell hatch did not disclose that he had reached into the cell of the man who died or touched the ligature. He told police that the man regularly spoke of trying to end his own life and that he had advised him against committing suicide. The prisoner stated that he did not believe he would do it. He described how he had gone to the man's cell having been told to "go and check on your mate" by the Health Care Assistant. On discovering the man hanging from the back of the

door, he said that he panicked and ran down to the nurse's office.

On 5 September, he was re-interviewed by the police, this time under caution. He maintained that he had not been at the door for seconds and that he did not do anything with the hatch of the door or the ligature. When challenged that he had been at the man's cell door for more than 50 seconds, he initially denied that he had been, but then apologised that he didn't know he was there for that long.

A file has been prepared for the Crown Prosecution Service and it is expected that a decision on prosecution will be made by the end of February.

11. POST INCIDENT ACTIONS

11.1 The man who died had a visit due on 18 May from his father and a friend. While the prison was trying to contact the father to break the news, it was learnt that they had arrived at the Visitor's Centre. They were seen by the Deputy Governor and the Chaplain (Safer Custody Manager)..

11.2 There was a commendable level of input from the Care Team and senior management in ensuring all staff who had been involved and the prisoners in Lower Medical had been supported.

11.3 The West Mercia police were called in and have conducted a full investigation. The police have seized all original documents. This caused some difficulty for the investigation team, as we were unable to satisfy ourselves that we had seen the documents in their entirety.

11.4 The prisoner who was allegedly bullying the man who died was transferred out to another establishment soon afterwards because of the effect the incident had had upon him. He was interviewed on 18 May 2004 by police but later declared unfit for subsequent interview by the police, who were unable to re-interview him until 9 September 2004.

12. LEVELS OF COMPLIANCE WITH PROCEDURES

SUICIDE PREVENTION AT BLAKENHURST

12.1 The Safer Custody Manager, a Chaplain., told us he spent about half of his time on safer custody issues. There had previously been a full time suicide prevention co-ordinator, but he had left the establishment some months before and had not been replaced. During the course of our investigation another prison officer was given responsibility for suicide prevention, but as he had only just taken up the role, we did not interview him. As the Safer Custody Co-ordinator, this role included the reduction of violence and caring for prisoners identified as at risk.

12.2 A full audit of the Standards Audit Unit modules on suicide prevention and follow-up to death in custody were conducted. Considering the establishment's recent history, and the number of action plans that had been produced as a result, we were disappointed that suicide prevention only scored 69%, an overall rating of Acceptable. There were a number of findings that caused concern, which we explored further when interviewing the Safer Custody Manager and Deputy Governor. The "Handling a Death in Custody" Standard received a rating of 70%.

F2052SH Procedures

12.3 We found that a number of reviews were being missed, or were not carried out properly;

- Of 20 F2052SH documents examined, the 72hr compliance was:
  8 reviews conducted within agreed time-scale
  6 reviews were late
  2 reviews not conducted
  4 reviews were not due at the time of the audit
- Of 20 F2052SH documents examined, the fortnightly compliance was:
  9 reviews conducted on time
  8 reviews were not due at the time of the audit
  1 review found to be overdue
  1 review was unsigned and not dated
- There was evidence that case reviews are multi-disciplinary with only an occasional review being conducted by house block staff only.

12.4 The main concern was with the quality of support offered and the comments made following case reviews. Initial support plans have not been completed or have a very basic level of support. For example, 'access to wing listener and staff.' Case reviews were missing the opportunity to encourage the prisoner to take an active part in the regime on offer, to self assess their current circumstances or to involve other departments in their positive progress.

12.5 There was no evidence to support the requirement of access to family and friends being met.

12.6 We have already noted that when the man went out on escort on 11 May, his F2052SH was left behind in the Lower Medical. We could not find an audit trail to satisfy us that measures were in place to ensure that the F2052SH for prisoners going out under escort would be handed over and checked on his discharge.

Suicide Prevention Strategy

12.7 The local suicide prevention strategy we found in residential areas was produced in 2002. There were a number of shortcomings in this relating to PSO2700:

- Checking F2052SH status – included in a checklist.
- Responding to individual physical and mental health problems during detoxification.
- Undertaking constant observation, covering the rotation of observation staff, interactivity between observing staff and the prisoner and when and how the prisoner can participate in normal regime activities.
- Reference to e-list prisoners.
- Ensuring prisoners in shared accommodation who have been risk assessed as needing constant company are not left alone.
- The manager of each unit must provide regular checks of the emergency response kit on the unit and ensure that it is replenished after each use.

During the course of the investigation a new policy was produced. However, although this was a more comprehensive document, it had drawn heavily on the strategy for HM Prison Bristol, and at the time of investigation, had not been localised to the specific needs at Blakenhurst.

Suicide Prevention Meeting

12.8 Attendance at the monthly Suicide Prevention Team meeting was irregular, and the Safer Custody Manager and Deputy Governor shared the chair. The Deputy Goveror said she chaired the meeting when she attended, although sometimes she had been in attendance but the Safer Custody Manager had taken the chair. The meeting did not review the quality of F2052SH files, claiming that they could not be taken away from the prisoners they related to. We could not see why the meeting could not review a sample of closed files. The audit of the meeting minutes could not determine whether any of the statistics provided were discussed. The Safer Custody Manager also said that action plans following death in custody reports were drawn up by himself and the Deputy Governor, away from the rest of the team. There did not appear to be any independent monitoring of progress against these action plans.

12.9 We consider that a number of the recommendations from previous death in custody action points have not been actioned, remain pertinent to this case, and we would look to repeat them. There was no audit trail from the previous action plans to confirm what had been completed, and by whom.

Training

12.10 One of the team interviewed the Training Manager who said that training had been arranged on a regular basis, which was supported by documentary evidence. However, more often than not, training had to be cancelled due to other operational priorities. A four hour session entitled Suicide Prevention had been scheduled from January through to June 2004. The newly recruited Officers had received the locally delivered suicide prevention training. However only two nurses and four medical staff had received the appropriate training. The Health Care induction pack for staff, only mentions F2052SH briefly and does not include the management of

those at risk of self-harm. Among management, only one Principal Officer and eight Senior Officers had received the appropriate training.

12.11 There was no record of the Senior Management Team having received appropriate training.

Listener Scheme

12.12 It was documented at the Safer Custody meeting that Listeners had difficulty accessing lower medical. A Samaritan, from the Worcestershire Samaritans confirmed that this was the case. He said that there were "some nurses who are very helpful and some aren't". However, he commented that co-operation from the prison "got significantly better when the Prison Service took over and it has been improving steadily every since". He felt that prison staff were now trusting the Samaritans and the Listeners and there was a greater readiness to call out Listeners at night. He believed that there was a will by management and by 95% of the staff to resolve problems.

13 FINDINGS

13.1 The man who died was remanded in custody in Blakenhurst on charges of killing his wife and children. The case had attracted considerable publicity. On 24 December 2003 he had deliberately crashed his car in an attempt to kill himself. When the police went to his family home, they discovered the bodies of his wife and two children.

13.2 He was received at Blakenhurst in early January and was admitted as an inpatient to the Lower Medical unit, both for mental health observations and also because he had a broken leg. A F2052SH had been opened on him by a CPN at court. He was eventually discharged to Houseblock 5, a vulnerable prisoners unit when his leg healed, and the F2052SH was closed as he appeared to be coping better.

13.3 In April 2004 concerns grew for his mental state, and he was assessed by a psychiatrist as unsuitable to share a cell. A second F2052SH was opened and he was moved back into Lower Medical.

13.4 Other prisoners on the unit knew about his alleged offence, and one prisoner told us that some other prisoners, one in particular, had been intimidating the man who died. Unfortunately, nothing had been said to staff before his death.

13.5 None of the nursing staff who worked in Lower Medical, when interviewed, appeared to have any close knowledge of the man's personality or mood.

13.6 Psychiatric assessments of the man indicated that he was severely disturbed and at a high risk of harming himself and others. It had been recommended that he should be transferred to secure mental health accommodation. However nothing was done to progress this. At the same time, he was observed making increasingly bizarre comments by prison officers and nurses who came into contact with him.

13.7 He was seen by a number of prison staff in the process of managing his risk of self-harm, including the chaplaincy. He saw a Quaker Chaplain volunteer, on two occasions, and a part time Chaplain, saw him on a regular basis. One of the support mechanisms that was proposed to help the man was bereavement counselling. The Chaplain provided informal bereavement counselling. He talked with the man about the reason and purpose of death and the man came to the conclusion it was better to live. However there was no formal professional service available in Blakenhurst, and the omission of this was not followed up.

13.8 When he went out on escort on 11 May, the man's F2052SH was left behind in the Lower Medical. There did not appear to have been any briefing or handover to the escorting officers as to his risk of self-harm. The PER that did accompany him was poorly completed, and the staff who escorted him recalled, when interviewed, that he was behaving bizarrely, but did not write anything down at the time.

13.9 At the time of his death, the man was on a F2052SH, on level three observations. A number of other prisoners in the unit were on higher levels of observation,

including two on constant watch.

13.10 The man was discovered hanging in his cell by another prisoner, the man who allegedly bullied him, at 11:36 on 18 May. He had a ligature made from a torn bedsheet around his neck, which was wedged under the hatch in his cell door. Staff attended quickly, entered his cell and attempted resuscitation but without success. He was pronounced dead by the Senior Medical Officer at 11:53.

Health Care

13.11 The management of health care at Blakenhurst was divided between a governor who dealt with operational matters such as the movement of difficult prisoners, and the Senior Nurse Manager of the Health Care Centre who had clinical responsibility. There was also a GP, the Senior Medical Officer, but he had no management duties.

13.12 Low staffing levels in the Lower Medical unit meant that it was common for the prisoners' regime to be curtailed, and they were kept locked up for long periods. When there were less than three staff on duty, everyone on the unit was locked up. All staff in the Lower Medical were nursing grades, with a mix of RMNs, RGNs and Health Care Assistants covering the unit. Discipline officers had worked in there prior to the Prison Service taking over in 2001. There were insufficient RMNs and those working in healthcare were described as traditional. The shift system combined all staff in a single team which did not provide a predictable number of RMNs on any one day.

13.13 All cells in the Lower Medical are single occupancy. A six-bedded ward had been closed to create a second association room, and the beds moved into other cells, but these cells were never used as double cells. We were told that the reason for this was that there were no privacy screens around the toilets. At the time our investigation started, the unit was dirty and had not been decorated recently. It is likely to have been the same when the man who is the subject of this report was held there.

13.14 Psychiatric services were provided by the Reaside clinic in Birmingham. There was a long-standing problem in getting patients seen by Reaside staff, whose attendance at Blakenhurst was erratic and then having them transferred on to secure accommodation.

13.15 The Lower Medical was supposed to be run as a ward, rather than a prison residential unit, which was why the Deputy Governor did not want prison officers working on it. However there was no system for having named nurses or individual care plans for prisoners.

13.16 The average population in the unit was about 14. There were also prisoners in Lower Medical who appeared to be housed there not for medical reasons because they posed a control problem as a climber, or as men who were vulnerable but were too disruptive on Houseblock five (e.g. the man who allegedly bullied the man who died). We saw evidence that these were marked up as "non-medical".

13.17 A multi disciplinary team meeting had been recently established to discuss and monitor the needs and progress of prisoners located in the healthcare centre and segregation unit. This was attended by the Deputy Governor, healthcare manager, clinical psychologist and a nurse for lower medical.

Suicide Prevention

13.18 Blakenhurst has had a number of deaths over the last two years which have each generated a Prison Service investigation with recommendations. A number of the reports made similar recommendations, due to their being common factors, particularly relating to the Lower Medical and suicide prevention training. Management checks of the quality of F2052SH completion were irregular and inconsistent. Even when it was established that reviews had not taken place on time, this was not always corrected immediately.

13.19 Listeners perceived that their role was not valued by healthcare staff. They frequently found it difficult to access lower medical.

13.20 A number of the staff interviewed had not received any training in the F2052SH process, although they were all familiar with the basics of it.

13.21 The suicide prevention meeting did not check F2052SH books as part of their standing agenda, and the action plans following deaths were not discussed by the meeting. They were drawn up, managed and monitored by the Deputy Governor and the Chaplain, who also held the post of Safer Custody Manager.

14 CONCLUSION

14.1 The Service Level Agreement for healthcare was not adhered to. In particular, the environment was not therapeutically orientated. There was a lack of staff intervention with in-patients located on lower medical, leading to limited knowledge of the man's psychotic condition and relationships with other prisoners. Insufficient management attention was given to the regime in lower medical and, in particular, to the effective development of staff. Prisoners were located in lower medical for non-medical purposes, which was contrary to the provision of a caring routine for prisoners. The numbers and skill mix of staff in the healthcare department was insufficient to provide such a regime.

14.2 The Senior Medical Officer described his title as being in name only. It was clear that he did not fulfil all the duties specified in the Service Level Agreement for the lead GP. The healthcare department did not fit clearly in the management structure. The Head of Operations had an operational responsibility for healthcare which he described as forming a "conduit between the PCT and healthcare staff locally and the healthcare manager and the SMT and the rest of the prison". He was also responsible for segregation units, visits, video links and escorts.

14.3 There was no professional bereavement counselling made available to the man who died despite this being recommended by case reviews. Potentially, this might have helped the man deal with the loss of his wife and children.

14.4 The lower medical unit was depressing and in need of redecoration and cleaning. The man who died did not receive the mental healthcare that a number of professionals suggested that he needed.

14.5 There were unacceptable delays in transferring prisoners to psychiatric hospital.

14.6 Arrangements for the ensuring that the F2052SH file is carried on all escorts are ineffective.

14.7 The cell door hatch provided a ligature point which could be removed by replacing it with a better design.

14.8 The Suicide Prevention Team failed to monitor the level of training. Insufficient priority was given to Suicide Prevention Training. Consequently, managers of all grades and healthcare staff did not fully understand the F2052SH process. Some healthcare staff were unsupportive of the work of Listeners.

14.9 Recommendations from previous death in custody reports have not been fully implemented, in particular relating to the management of suicide prevention procedures. At the time of investigation, the shared cells in lower medical had never been used for double occupancy.

14.10 Everything possible was done to resuscitate the man and, after his death, a high level of support was offered to staff and prisoners. Particular mention should be made of the role of the Deputy Governor, whose caring and supportive attitude was praised by many prisoners.

RECOMMENDATIONS

1. Although not pertinent to this death, the shared cells in healthcare should be brought into use. Priority should be given to the procurement of privacy screens.

2. The Suicide Prevention Committee should review closed F2052SH at their meetings.

3. The Suicide Prevention meeting should monitor the level of suicide prevention training. Priority should be given to training healthcare staff and senior managers. Wing managers should be given refresher training in the completion of case reviews.

4. A professional bereavement counselling service should be made available to prisoners. This is particularly pertinent to those charged or convicted of murdering partners or family members. These prisoners should be seen as high risks, particularly whilst on remand and during the early stages of their sentence.

5. A system should be established for ensuring that reviews take place on time and that relevant staff are contacted and attend. This is particularly pertinent for healthcare staff in the case of prisoners who have recently been inpatients or who are receiving ongoing support from RMNs or the In-Reach team.

6. The quality of support plans should be improved and should include the use of family members to support prisoners at risk of self harm.

7. The post of suicide prevention co-ordinator should not be allowed to be unfilled for a lengthy period again.

8. Action plans should identify the action taken to make the previous finding compliant and include the person responsible and when the action was taken or is planned.

9. There should be an independent check of the completion of action plans produced following a death in custody.

10. The skill mix in healthcare should be reviewed. The shift pattern should provide greater continuity and predictability in lower medical. A therapeutic, meaningful regime should be provided.

11. An effective relationship must be established with Reaside to ensure that prisoners with severe mental health problems can be transferred to an appropriate hospital if necessary.

12. An additional column should be included in the night orderly officer's checklist to record action taken by the Deputy Governor to rectify non compliance.

Glossary of Terms

Canteen	The prison shop, where prisoners order food, tobacco, toiletries and telephone credits. Orders are submitted once a week and the orders are delivered in sealed bags
OSG	Operational Support Grade
Off	Officer
PO	Principal Officer
POELT	Prison Officer Entry Level Training – a term used to refer to newly trained officers.
SO	Senior Officer
Gov	Governor – Operational prison managers (there are six ranks, Senior Manager A being the highest)
PSO	Prison Service Order: nationally set mandatory instructions.
POA	Prison Officers' Association
F2050	Main Core Record
F2052SH	Self Harm at Risk Form for prisoners at risk of self-harm
IMR	Inmate Medical Record
F2052A (History Sheet)	A file recording events relating to an individual prisoner (Wing based)
LIDS	Local Inmate Database System - the computer system that holds basic information on prisoners' movements, activities and custodial dates
F213	Injury Report Form
F213SH	Self Harm Injury Report Form
IRS	Incident Reporting System - a national database of incidents that must be reported by computer to headquarters