The Death in Custody of

a man at

HMP Altcourse – July 2005

Report by the Prisons and Probation Ombudsman for England and Wales

April 2006

This is the report of an investigation into the circumstances of the death of a man at HMP Altcourse on 12 July 2005. The man was found hanging in his cell in the Vulnerable Prisoner Unit. He was 25 years old.

The investigation was carried out by one of my colleagues.

The man was a quiet and reserved person who spent the whole of his five months at Altcourse in the Vulnerable Prisoner Unit. His reason for being there was that he was in fear of those co-accused with him. Despite this very specific concern and his obvious shyness, the man seems to have been quite settled at Altcourse and it came as a surprise to all that he should apparently have taken his own life. He did so seven weeks after being convicted of supplying class A drugs.

I have made four recommendations. One of these concerns escort arrangements, two concern emergency response and one concerns suicide and self-harm monitoring.

I extend my sincere condolences to the man's family and friends for their loss. I would like to thank the Director of Altcourse and his staff for their help.

Stephen Shaw CBE **April 2006**
Prisons and Probation Ombudsman

CONTENTS

SUMMARY

In February 2005, the man, who was 25 years-of-age, was received into HMP Liverpool as a remand prisoner charged with conspiracy to supply class A drugs. On 18 February, the man was transferred from Liverpool to HMP Altcourse. Previously, the man had spent two days as a remand prisoner in Altcourse in January 2002 and he had served six weeks in HMP Liverpool at the end of 2002 into early 2003.

When the man arrived in Altcourse in February he immediately asked to be located on the Vulnerable Prisoner (VP) Unit, which is based in Reynoldstown Blue (one half of Reynoldstown wing). Vulnerable Prisoner Units house those who may be at risk from other prisoners. Most usually, VPs are sex offenders. The man's reason for asking to be located into Altcourse's VP unit was that he was in fear of his co-accused, who were also in Altcourse.

The man seems to have been reasonably content in Reynoldstown Blue. He complained at one stage that he was being bullied by his cell-mate, but when he informed staff about this he was moved to a different cell. The man was a quiet, shy, reserved person who did not confide in others, but he did take part in some activities. He ate his meals in the dining area rather than in his cell and he worked each morning in the prison laundry.

On 25 June, Reynoldstown wing's Residential Manager noticed that the man seemed distressed. He explained to her that he had been threatened by his co-accused, against whom he had testified in court. The man said that he could not cope any longer and that he wanted to harm himself. As a result, the man was placed on special monitoring – the F2052SH procedure. It would seem that some of these threats were being made when the man and his co-accused were travelling from prison to court and back.

Observations of the man when subject to special monitoring indicate that he was behaving normally throughout this time with no incidents of deliberate self-harm. He continued to spend time outside of his cell and he continued to go to work. On 7 July, the need for the man to remain on special monitoring was considered at a weekly review panel. Ahead of the meeting, the man wrote a statement to say that he was content to be taken off monitoring and that he had had no recent thoughts of suicide. The panel agreed that special monitoring should cease. By this time, the man had been found guilty on two counts of supplying class A drugs, but was awaiting a further court appearance for sentencing.

On the morning of 12 July, the man went to work as normal. At lunchtime the man's cell-mate went to their cell and he gave the man

some tobacco. The man's cell-mate then returned to work – he works afternoon as well as morning shifts. The cell-mate said that Mr The man was his usual self that day.

At about 4.20pm, another of the prisoners went to the man's cell, looked through the cell door observation hatch and saw the man hanging. The prisoner shouted to staff who responded without delay. Three officers went into the man's cell and were able to support his body weight and pull away the ligature. Healthcare staff arrived, as did ambulance paramedics. Resuscitation was attempted, but without success.

Nothing has emerged from this investigation to suggest that staff could have anticipated that the man was especially at risk of self-harm or suicide either that day or in the days immediately before 12 July.

My report makes four recommendations. I have recommended that prisoners should be transported to court separately from prisoners against whom they are to testify. I have recommended that prisoners subject to special monitoring should attend review panel meetings. And I have made two recommendations in connection with staff response when a possible death in custody is discovered.

INVESTIGATION PROCESS

The investigation was opened on 15 July 2005 when my colleague visited Altcourse when he had separate meetings with the Director, with Altcourse's Head of Resettlement, and a representative from the staff trade union. My investigator informed them of the nature and scope of the investigation. Notices were issued to staff and prisoners notifying them of the investigation. This resulted in two prisoners contacting my investigator and they, along with eleven members of staff and two other prisoners, were interviewed formally.

My investigator also informed the man's parents about the investigation

North Liverpool Primary Care Trust carried out a clinical review of the man's clinical care and treatment.

HMP ALTCOURSE

HMP Altcourse is a local prison on the outskirts of Liverpool. It was opened in December 1997 and is managed by GSL UK Limited.

The prison's residential areas consist of six main house blocks, each divided into two units holding up to 83 prisoners in each unit. Separate buildings contain the healthcare unit, rehabilitation unit, college, sports centre and segregation unit. Altcourse has an operational capacity of 903 prisoners.

In her report of an announced inspection in February 2005, Her Majesty's Chief Inspector of Prisons declared Altcourse to be a very good local prison. It was found to have a good suicide and self-harm (SASH) prevention policy with prisoners subject to SASH procedures reporting regular contact with staff and reporting that they generally felt supported.

Cell doors at Altcourse are fitted with courtesy locks to allow prisoners to lock their doors if they want some privacy and time away from other prisoners. Prisoners are issued with keys to their doors. The keys carried by officers will override the courtesy lock to open doors that have been locked by prisoners.

EVENTS LEADING UP TO THE MAN'S DEATH

In February 2005, at a Magistrates' Court, the man was remanded into custody at HMP Liverpool in connection with charges of conspiracy to supply class A drugs. Two others were accused of the same charges and the man was later to become a prosecution witness.

At his first reception health screen at Liverpool on 9 February, the man reported that he was taking Paroxetine (an anti-depressant) and was also taking methadone that was being prescribed by a community drugs team for detoxification from opiates. The man saw a prison doctor the following day when he reported that he was a user of heroin and cocaine. The man also reported acts of deliberate self-harm: inflicting cuts and cigarette burns to his arms as a release from pain. The doctor judged that the man was at low risk of deliberate self-harm at that particular point in time and that there was no reason to open an F2052SH for him to be specially monitored. The doctor referred the man to the prison's drug detoxification team.

On 18 February, the man was transferred from Liverpool to HMP Altcourse. On arrival at Altcourse, the man reported that he was fearful about his co-accused labelling him a 'grass' and he asked, and was accepted, to be located into Altcourse's Vulnerable Prisoner unit. The VP Unit is based in Reynoldstown Blue wing. The man's co-accused were also in Altcourse, but were in other wings of the prison. During a standard health check review for a prisoner newly transferred from another prison, a note was made that the man had a history of self-harm.

The man's Personal Officer explained at interview that the VP Unit holds people who, for a variety of reasons, are unable to cope in a standard prison wing or who might be a target for bullying in a standard wing. The personal officer's specific responsibilities for the man included dealing with his sentence planning, his custody reviews, day-to-day problems and generally ensuring that he was okay.

The Personal Officer described the man as a quiet person, but she said that he did mix with other prisoners and did take part in activities to some extent. He also had a job in the prison laundry that he seemed to enjoy. The Personal Officer said that her practice is to spend a lot of time talking with those for whom she is the appointed personal officer. She said that prisoners often need to talk with a person who is not another prisoner. The Personal Officer said that it took her a while to gain the man's trust. But in time he began to open up and to be a bit more forthcoming. When they spoke at the time of his reviews, he would smile and giggle. She felt that they ended up almost as friends, insofar as that is possible between an officer and a prisoner.

During the man's custody plan review on 19 March, the Personal Officer recorded him saying that he was comfortable being in the VP Unit and that he thought that everybody in the unit had a good attitude. In connection with his offences, the man said that he had been forced into supplying drugs as he owed money to the dealers.

On 17 April, the Personal Officer noted in the man's records that he had complained about being bullied by his then cellmate. The man was moved to another cell and he was then noted to be a lot happier.

The major issue of concern to the man throughout his period in custody were his court appearances. He was concerned in particular about contact with his two co-accused and that he might have to share a cell with them when at court. The Personal Officer made a note in the man's custody plan about this on 21 June (the man had been convicted on 20 May on two counts of conspiracy to supply class A drugs but was awaiting a further appearance at court for sentencing).

The Residential Manager for Reynoldstown wing, said that the man was a quiet person who tended to keep himself to himself. He was someone who complied with the rules, worked, and posed no problems. The Residential Manager said that the man had been the target of some bullying in his first few days at Altcourse. However, this had been due to a group of prisoners bullying numerous other prisoners as well as the man. These prisoners had been dealt with and The Residential Manager was unaware of the man having any further problems in the unit.

On 25 June, the Residential Manager placed the man on special monitoring – the F2052SH process. The Residential Manager made a note that the man was distressed about his court case and about threats being made against him by his co-accused. He said that he could not cope any more and that he wanted to harm himself. The Residential Manager saw the man again on 27 June for a case review. Although the man was still feeling uneasy about his co-accused, he said that he was feeling more settled. The Residential Manager said at interview that she reassured the man that he would be kept apart from his co-accused. The man was kept on special monitoring.

Each week on a Thursday, a multi-disciplinary review panel meets to consider whether or not prisoners subject to F2052SH monitoring should continue to be monitored. Prisoners do not attend review panels, but they are asked to write a statement to be read-out at the meeting. At the time that the man was in Altcourse, these comment forms were distributed to prisoners on Tuesday evenings, they are now distributed on Wednesdays. Comment forms are not signed, dated or timed. The man's statement for the review panel meeting on Thursday 30 June

included: *'I am having trouble coping at the moment. This is because my co-defendants (who are in this prison) want to harm me. I get very worried when I am going to court as they shout abuse at me on the bus. This makes me want to kill myself ...'*

Records show that there were occasions when the man was transferred to or from court in the same van as one or both of his co-accused. Prisoners are transported in cellular vans – that is, vans which contain separate cells or cubicles ensuring that each prisoner is kept separate from every other. Prisoners are taken into and out of the van one at a time so that no prisoner can see which other prisoners are being moved with them. However, cubicles are not sound proofed so prisoners are able to converse.

The outcome of the review panel's consideration on 30 June was that the man should remain on special monitoring.

On 3 July, the man was seen by a registered mental health nurse (RMN). The referral to the mental health team had been made on 26 June following a consultation with a prison doctor, which in itself had taken place as a routine part of the F2052SH process. The man reported to the RMN that he was fearful of other prisoners and had thoughts of self-harm. The man denied having any mental health issues but, as he was feeling anxious, the RMN arranged for him to see a doctor for a review of his medication. The RMN made a note in the man's medical record that he would see him again. At interview, the RMN said that the opportunity to see the man again did not arise.

Following the arrangements made by the RMN a prison doctor saw the man on 4 July. At interview, the doctor said that the man was complaining of hearing voices in his head that he would be attacked by his co-accused and he was seeking a change to his medication dosage. The doctor increased the man's night-time dose of olanzapine (an anti-psychotic) for its sedative benefits. The doctor said that the man had first been prescribed olanzapine at HMP Liverpool when he had been assessed by a psychiatrist who made a dual diagnosis of drug misuse and possible schizophrenia.

Ahead of the weekly F2052SH review panel meeting on Thursday 7 July the man wrote the following statement: *'I am happy to come off my suicide watch as recently I have not felt suicidal.'*

The Resdential Manager was one of the eleven people making up the review panel on 7 July that decided that the man no longer needed to be kept on special monitoring. The Residential Manager said that there had been a marked improvement in the man's mood from the time she had opened the F2052SH on 25 June.

The role of the Suicide and Self-Harm Co-ordinator at Altcourse includes auditing of F2052SHs. The Suicide and Self-Harm Co-ordinator was also at the review panel meeting on 7 July. Reviewing the record of the observations of the man's behaviour during the period of his monitoring, the Suicide and Self-Harm Co-ordinator said that these show that he was going to work, was playing pool, was going to the library and was sleeping well at night. These entries, she said, do not indicate any reason for concern.

One of the two Heads of Residence at Altcourse and was also a review panel member on 7 July. The Head of Residence said that panels have a multi-disciplinary make-up with representatives from senior management, unit officers, counsellors and clinicians including a doctor. There is sometimes disagreement about whether or not a prisoner should be removed from special monitoring but, in cases of doubt, panels will err on the side of caution.

On 9 July, The Personal Officer made a note in the man's records that he appeared nervous about a forthcoming court appearance. The note went on to say that he was not thinking about harming himself. At interview, the Personal Officer said that she had asked the man that day if he was content about having been taken off special watch and he said that he was. The Personal Officer said that she believed that the man was uncomfortable about being watched all the time and so was happier when he was no longer subject to special watch. She was shocked that the man later took his life; she had not expected him to do such a thing.

Other officers working in Reynoldstown wing described the man in very similar terms to the Personal Officer and the Residential Manager. The first PCO said that the man was quiet and reserved and did not mix much with other prisoners. However he did have friends and he would approach staff if he needed something such as help with arranging visits. The man worked; he kept his cell clean; he was a 'model prisoner'. The second PCO said that the man was very shy and would appear embarrassed and would look away if she smiled at him. Although he did not mix very much with other prisoners, there was no change in his behaviour in all the time that he was in the unit. It was normal for him to be quiet and reserved. The third PCO gave similar evidence to all the other staff who encountered the man. Although an extremely quiet individual, he took part in wing activities and would come out of his cell at meal times to eat in the dining area. The third PCO acknowledged that prisoners from other parts of the prison would often shout abuse at prisoners in the VP Unit – many of the prisoners in the VP Unit are sex offenders – but there was nothing to make the third PCO believe that the man was unduly concerned. Indeed, some of these incidents were

reported to have taken place at chapel but the man was not deterred from returning to chapel on the following Sunday.

The man's cell-mate also described the man as a very quiet person who kept himself to himself and did not talk much about his personal feelings. However, he played snooker and table tennis with other prisoners. The cell-mate said the man got on well with everyone and everyone liked him.

The cell-mate said that the man was concerned about his co-accused in his court case and had received abuse from these prisoners when going to chapel and also on the van going to court. The man was concerned that he might have to share a cell with them at court, although the man's cell-mate was aware that staff had assured him that this would not happen. (In fact, and entirely properly, the man never was required to share a cell with these other prisoners.) The man's cell-mate added that staff in the wing were good and were receptive when prisoners wanted to have a 'quiet word' with them.

The man's cell-mate works double shifts in the laundry, usually from 6.30am to 9.30pm. On 12 July, he collected some belongings from his cell at lunchtime and gave the man some tobacco. The cell-mate then went back to work. He said that the man was his usual self that day. Later that afternoon, the cell-mate was called into the wing office and told about what had happened. The cell-mate said that he never had any suspicion that the man would harm himself. He had even remained in good spirits at the time he was subject to special monitoring when perceived to be at risk of self-harm.

THE DISCOVERY OF THE MAN'S DEATH

Another of the prisoners in Reynoldstown Blue wing said that he and the man were friends. Shortly before 4.25pm on 12 July, the prisoner went to the man's cell. On looking through the door observation hatch, he saw the man hanging from the toilet door. The prisoner alerted the staff and they responded immediately.

The second PCO was sitting at the central console which is located in the ground floor of Reynoldstone Blue wing and was speaking on the telephone to the third PCO who was in the wing office. The second PCO said that she heard prisoners on the first floor landing shouting to attract her attention. She ran up the stairs to the man's cell and saw from the door observation window that he was hanging. The second PCO went into the cell and tried to lift the man, but he was too heavy for her. At that point, the first PCO entered the cell followed by the third PCO. Between them they were able to lift the man while the first PCO slipped the ligature from the man's neck. The second PCO said that the man was warm to the touch, but his tongue was protruding and his appearance indicated that he was already dead. When the second PCO checked for a pulse, she could find none. The second PCO said that she had a moment of shock and did not think about starting cardio-pulmonary resuscitation (CPR). However, within seconds, healthcare staff arrived.

The third PCO was speaking by telephone with the second PCO when the telephone went dead. The third PCO realised that this meant that there was a problem so she ran out of the office and followed the second PCO. Between them, they released the man from the ligature and he fell to the floor. She said that the man's lips were blue and his tongue was swollen. The third PCO said that the other two PCOs were at either side of the man so she left the cell to lock away the prisoners who were congregating outside the cell.

The first PCO said that he was in the wing office with the third PCO when she ran out of the office. The first PCO said that an officer running usually means a problem so he followed and pressed the first response button on his radio at the same time. (A first response call is an alert for assistance from senior and healthcare staff. The first PCO's call was logged at 4.25pm.) The first PCO overtook the third PCO and when he reached the top of the stairs saw the second PCO opening the man's cell door. They went into the cell, lifted the man and slipped the ligature from his neck. The man fell to the floor. The first PCO radioed the communications room that it was a Code One incident (a Code One signifies a prisoner with breathing difficulties requiring urgent medical assistance).

The first PCO said that he left the cell at that stage due to lack of room. He did not check the man for signs of life, nor was he involved in the attempts made to try to resuscitate the man. The first PCO said that he did not carry a mouth shield (a mouth shield is a piece of equipment which offers protection to a person giving mouth-to-mouth aid with breathing) and indicated that he would not want to give mouth-to-mouth aid.

The Nurse explained at interview that healthcare staff always respond to first response calls in case a prisoner or member of staff needs treatment. The Nurse was with another Nurse in the healthcare unit on the afternoon of 12 July when they heard a first response call and they began to run to the scene. They took with them a small medical bag containing the dressings and equipment usually sufficient for a first response incident. They had already left the healthcare unit when they heard on the radio that the incident had been escalated to a Code One response. They continued running to the scene knowing that other healthcare staff would follow with the emergency medical equipment always taken to a Code One incident, such as a defibrillator and oxygen. The Nurse estimated that, from the point of hearing the first response call, it had taken around two minutes to reach the man's cell. As they arrived, the Nurse asked if an ambulance had been called and she was told that was the case (the 999 call was logged as being made at 4.28pm). Staff were not attempting to resuscitate the man, but the Nurse thought that this was because the man had only just been released from the ligature and placed on the floor. The Nurse checked the man for a pulse and signs of breathing but found no such signs. Although the man's condition indicated that he was probably already dead, the Nurse commenced giving chest compressions while her nursing colleague carried out mouth-to-mouth breathing. Other healthcare staff arrived with oxygen and the defibrillator and then the prison doctor and ambulance paramedics also arrived. Attempts to resuscitate the man continued for 20 or more minutes until everyone agreed that their efforts would not be successful and should cease.

The prison doctor's entry in the man's medical record states that testing with the defibrillator showed that the man was asystole (meaning that he had no cardiac output). The doctor said that it had not been possible to pass a tube into the man's airway to assist in giving oxygen because his jaw was rigid. This was possibly due to oedema (swelling caused by fluid build up in body tissue). Attempts to gain intravenous access to give the man emergency medication were unsuccessful due to the damage to his veins caused by his use of drugs. Attempts to resuscitate the man were made but were discontinued at 4.40pm and he was pronounced dead at 4.41pm.

AFTER THE MAN'S DEATH

Altcourse's Family Liaison Officer, accompanied by one of the prison chaplains, visited the man's parents in person to break the sad news of their son's death. In her report of the visit, the chaplain noted that the man's parents said that their son had been okay the last time they had spoken to him by telephone and that they had been planning to visit to take him some clothes.

A letter of condolence was sent by the prison to the man's parents and an offer was made to them to visit the prison. Altcourse also offered assistance with funeral arrangements and expenses.

FINDINGS AND CONCLUSIONS

Having first been taken into custody at HMP Liverpool on 9 February, the man was then transferred to Altcourse on 18 February where he was located into the Vulnerable Prisoner (VP) Unit. This was at his own request because he was fearful of other prisoners at Altcourse who were jointly accused with him on drugs charges and against whom he was to be a witness for the prosecution.

The man was consistently described as a quiet and reserved individual. His cell-mate said that he was someone who did not talk much about his personal feelings. However, it seems that the man was able to settle into the VP Unit and he appears to have coped well when he and others received abuse from prisoners from the standard prison wings. The man worked part-time in the laundry, which he seemed to enjoy; he took part in some wing activities; he ate his meals in the dining area and he had some friends. The man was compliant with the rules and was described by one officer as a 'model prisoner'. The man's Personal Officer said that it had taken the man a little while to learn to trust her, but in time she felt that they established a good relationship.

The man was convicted on two counts of supplying drugs on 20 May, although he was due to return to court at a later date for sentencing. On 25 June, the Resdential Manager observed the man to be distressed. He said that his co-accused had been making threats, he felt he could not cope any longer and he wanted to harm himself. The Resdential Manager placed the man on special monitoring.

Each Thursday, prisoners subject to F2052SH monitoring are discussed at a multi-disciplinary review panel meeting to consider whether or not monitoring should continue. Prisoners do not attend review panel meetings. Instead, they are asked to write a statement. In his statement ahead of the meeting of 30 June, the man stated that his co-accused were shouting abuse at him when going to court. Prisoners are transported to and from court in cellular vans into which they are placed one at a time. In theory, no prisoner will know who else is in the van. However, cubicles are not sound proofed and it would not take long for prisoners to establish communication with one another and to establish who else is in the van.

When the man's case was discussed at the review on 30 June, it was decided that he should remain on special monitoring.

Ahead of the review panel meeting of 7 July, the man wrote a statement to say that he was happy to come off monitoring then, as he no longer felt suicidal. The panel were content with the man's progress since being placed on monitoring and agreed that it should cease.

In considering the decision to remove the man from special monitoring I am mindful of the fact that his records show that his fears and concerns were all very specifically focussed on his court appearances and contact with his co-accused. With the benefit of hindsight, one might argue that it would have been prudent to have maintained special monitoring of the man until after his court case had been concluded absolutely. However, I note that the man had not actually committed any acts of even minor self-harm in the five months he was at Altcourse. I also note that the record of observations while the man was subject to special monitoring shows him to have been behaving normally and going to work as usual. Based on the evidence available to the review panel on 7 July, I conclude that the decision to take the man off special monitoring that day was appropriate. Moreover, nothing arose in the days following 7 July to warrant a review of that decision.

In line with Altcourse's practice, the man did not attend the review panel meeting on 7 July. Instead, his written statement was presented. In contrast, it is common practice at most prisons for prisoners to attend at least part of the review meeting. This allows panel members to explore such things as any support networks that the prisoner may have. The prisoner's attendance also ensures that the panel is basing its assessment on the prisoner's mood and mental state as it stands at that moment in time. In the man's case, we do not know when he wrote the statement presented at the meeting on 7 July, although it could not have been written any earlier than on the evening of Tuesday 5 July.

On 9 July, the Personal Officer made an entry in the man's records that he was feeling nervous about a court appearance, but that he had no thoughts of self-harm. At interview, the Personal Officer was clearly enthusiastic about that role and her responsibilities in the VP unit. She said she was shocked that the man took his life and she was visibly upset when saying this.

On 12 July, the man went to work in the morning as usual. At midday, the man's cell-mate went to their cell to collect some belongings. He gave the man some tobacco and returned to work. The cell-mate said that there had been nothing to indicate that the man was at risk that day. Like the Personal Officer, the man's cell-mate was also visibly upset at interview.

At around 4.20pm that afternoon, another prisoner went to the man's cell, saw him hanging and alerted the staff. Three Prison Custody Officers responded without delay and were able to support the man's body as they removed the ligature from his neck. The second PCO

checked the man for a pulse, but that was the only clinical act from any of the three before the arrival of healthcare staff. However, it does seem that healthcare staff arrived on scene very quickly. Indeed the Nurse thought that at the point of her arrival the man had only just been taken down to the floor.

I remain unclear as to the identity of the person who instigated the summoning of an ambulance. None of the first three PCOs to attend to the man did so – instructions to PCOs require them only to summon assistance from healthcare staff. However, when the Nurse arrived she was informed that an ambulance had already been called.

Altcourse's instructions to officers arriving first at a possible death in custody state: *'If a prisoner is found and there is a possibility of death ... inform the Control Room … and request urgent medical assistance ... DO NOT automatically assume death – render first aid ...'*

Despite this instruction, I am concerned that interviews with PCOs indicate that the man would only have received first aid once healthcare staff arrived. The third PCO left the cell as soon as the man was taken to the floor – she said that the other two PCOs were at either side of the man so she left to lock away the other prisoners, some of whom had congregated outside the cell. The second PCO acknowledged that she suffered a moment of panic. The first PCO said that he did not carry a mouth shield and did not relish the thought of giving mouth-to-mouth resuscitation. That said, it appears that healthcare staff arrived very quickly and, that from all descriptions given, the man's life could not in fact have been saved.

The PCT, in its clinical review, has commented that it appears to be a significant omission that the man was not seen by another clinician after 4 July in light of the comments made during his consultation on 3 July with the RMN. The RMN's intention had been to see the man again, but had not done so by the time of the man's death. Having taken further clinical advice on this matter, I do not agree that it was a 'significant omission' that the man was not seen again during the week that elapsed since his previous consultation. At the consultation with the RMN, the man had expressed anxiety about his co-defendants and had said that he was considering self-harm. The RMN arranged for the man's medication to be reviewed and this led to the doctor increasing his dose of olanzapine the following day. Of course, the man was also subject to self-harm monitoring at this time.

The PCT has also expressed concern that the RMN did not attend the review panel which decided on 7 July to remove the man from self-harm monitoring. I do consider it would have been best practice to have included the clinician who had had significant contact with the

man. However, the panel members did include one of the prison doctors. As already stated, the man did not himself attend the panel and I have made a recommendation about this.

Records and record keeping are an essential part of the clinical care of patients in order to ensure effective communication and appropriate care planning between the multi-disciplinary team. It is essential that all clinical staff make appropriate and timely entries in patient medical records and I support the recommendation made by the PCT.

RECOMMENDATIONS

The following recommendations were made in the draft report. The Prison Service's responses to the recommendations are included in italics following each recommendation:

1. The Director and escort contractor should ensure that prisoners who have agreed to act as witnesses for the prosecution should travel to court separately from those against whom they are to testify.

Service Response: *If such cases present in the future the establishment will seek to transfer the prisoner under threat to another local prison. Failing this the establishment will ensure the safety of the prisoner under threat by having him escorted to court by prison staff. This is not a national policy but has been accepted by the Director of Altcourse.*

2. The Director should put a system in place to ensure that prisoners subject to suicide or self-harm monitoring may attend case review meetings.

Service Response: *Prisoners subject to F2052"SH procedures are invited to attend case review meetings.*

3. The Director should review the instructions to the first officer on scene of a possible death in custody to allow that officer to request an ambulance be summoned.

Service Response: *Instructions have been issued.*

4. The Director should ensure that all staff who might arrive first at a medical emergency always carry a mouth-to-mouth shield. Staff should be reminded of the instruction to the first on scene about rendering of first aid.

Service Response: *Mouth to mouth shields have been ordered and will be issued to staff. Target for completion is end of February 2006.*

RECOMMENDATION FROM CLINICAL REVIEW

Where healthcare staff are involved in decisions to open or close an F2052SH form, then their contribution should be recorded in the clinical notes.

Service Response: *Now in place.*