

**Investigation into the circumstances surrounding the
death of a man
at HMP & YOI Parc in August 2010**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

October 2011

This is the report into the circumstances surrounding the death of a man, less than four weeks after his transfer to HMP Parc. He was discovered hanging in his cell by staff in August 2010. He was 29 years old.

I offer my sincere sympathy and condolences to the man's family and friends for their loss. I must also apologise for the length of time it has taken to issue this report and any additional distress the delay may have caused.

The investigation was carried out by one of my senior investigators. A clinical review of the man's healthcare was undertaken by the local PCT. I am grateful for their comprehensive detailed report. I would also like to thank the Director of Parc and her staff for their co-operation and assistance with this investigation.

The man was serving an indeterminate sentence for public protection. The Parole Board told him he needed to complete a drugs course and spend time in a therapeutic community. He transferred to Parc but quickly felt it was a backward move. His mental health suffered and he was admitted to the inpatient healthcare unit for respite and assessment. Staff opened a support plan for him under the suicide prevention and self-harm management procedures and referred him to the mental health in-reach team but he was not taken onto the team's caseload.

The man's sister passed to prison staff details of a very worrying telephone conversation she had with her brother. The duty nurse in the inpatient unit received the information, which should have led to increased support for him. She did not take any action and, in the early hours of the following morning, staff found him hanging in his single cell. In spite of resuscitation attempts, he died.

HM Chief Inspector of Prisons carried out an inspection of Parc shortly after the man's death. He judged that healthcare services "were not delivered to an acceptable standard". The clinical reviewer notes, "chaos and a crisis within their Healthcare in-patient facility". Primecare Forensic Services provided primary healthcare services at Parc until September 2010, when G4S took over responsibility for healthcare. I am sending a copy of this report to the managing director of Primecare for his information.

In many instances, prisoners give no warning of the action they intend to take. While I cannot speculate on the likely outcome had staff intervened, it is clear that the man's care should have been enhanced had staff taken appropriate action in respect of the information received from his sister. I make seven recommendations, covering suicide and self-harm procedures and clinical practices and procedures, repeat and endorse a further five made by the clinical reviewer and endorse all other recommendations in the clinical review.

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

**Nigel Newcomen CBE
Prisons and Probation Ombudsman
2011**

October

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SUMMARY

1. In May 2007, the man was sentenced to a term of Imprisonment for Public Protection (IPP) with a tariff of two years and 145 days. It was not his first time in prison and on two occasions he had harmed himself. He had mental health problems and spent a lot of time in healthcare units.
2. A Parole Board hearing in April 2010, while the man was at HMP Littlehey did not approve his release or move to an open prison. The Board recommended that he complete a drugs course and spend time in a residential drugs programme. A drugs worker began the process of arranging finance for him to stay in a therapeutic community on his release from prison.
3. However, the man was bullied by other prisoners after falling into debt through buying drugs. As Littlehey does not have a vulnerable prisoners unit where he could have gone for his own protection, he moved to the segregation unit. Staff arranged a transfer to another prison where he could return to the standard wing. At his suggestion, they arranged to transfer him to Parc.
4. The man arrived at Parc on 5 August 2010 and quickly discovered that the drugs course he hoped to complete was not available at the prison. His mood, which had been positive about the move, quickly deteriorated and he told his family that the transfer had been a mistake. On 11 August, staff were so concerned about him that they opened a support plan and then admitted him to the inpatient unit for respite.
5. At the time, the healthcare services were in the process of passing from Primecare Forensic Services to G4S and there were serious issues around staffing levels. The inpatient unit was understaffed and the men there spent long periods in their cells. Staff made notes about the man in the self-harm monitoring plan (as well as his medical record) but did not use the plan to tailor the support he needed.
6. On 23 August, the man telephoned his sister. She was so alarmed by what he said that she telephoned the prison and spoke to one of the chaplains. She told him that he had told her to look after their mother and the previous time he said that to her, he had gone on to self-harm. The chaplain passed the message to the nurse in the inpatient unit but, instead of increasing the care and support for him, she did nothing. She did not record the message and warning in either the self-harm monitoring document or medical record.
7. At 12.30am the following morning, the duty member of staff found the man hanging in his cell. In spite of the efforts of staff who carried out CPR and treatment by paramedics, he was pronounced dead forty minutes later.

8. Given the distance between the prison and the home of the man's next of kin, Parc arranged for staff from a nearby prison to break the news to the family. The Director then visited the family the following day. Following his death, a hot debrief was held and staff were offered support by the prison's care team.
9. The investigation has shown that the man's physical and mental health needs were not treated to the standard that would have been expected in the community. I make five recommendations concerning the suicide and self-harm management procedures and provision for those with mental health needs, repeat and endorse a further five made by the clinical reviewer and endorse the other recommendations in the clinical review.

THE INVESTIGATION PROCESS

8. My office was notified of the man's death on 24 August 2010. The investigation was opened a week later when the investigator visited the prison. She spoke to the Director, Controller (who is responsible for managing the prison contract), members of the Independent Monitoring Board (IMB members are independent volunteers who monitor the day-to-day life in their local prison and ensure that proper standards of care and decency are maintained) and union and the head of Healthcare. She also visited the man's cell and looked round the inpatient unit and collected his prison records.
9. Notices were issued to staff and prisoners informing them of the investigation and inviting anyone who had relevant information to contact the investigator. There were no responses.
10. The investigator asked the local PCT to commission an independent review of the clinical care the man received whilst at Parc.
11. The investigator and the clinical reviewer visited Parc twice to interview staff. Together they interviewed 13 staff, the clinical reviewer alone interviewed two nurses and the investigator spoke by telephone to two members of staff from Littlehey. They were unable to interview one nurse, as she was suspended from duty during my investigation. They could not speak with the Healthcare Assistant, as she was on long-term sick leave. Prison staff were unable to provide any details of who one member of staff was, only that she no longer worked at Parc, so she was not interviewed.
12. One of my family liaison officers contacted the man's family to ask if they had any questions or issues they wished to discuss. She and the investigator later visited the family when the man's mother, sister and brother-in-law set out their many concerns. These covered the self-harm support procedures and whether they had been carried out to a good standard, whether he had been watched carefully enough, the reason for his transfer to Parc and why staff had not acted after their warning telephone call. After receiving the draft report, the family passed their comments to the family liaison officer. I am grateful for their time taken to consider report and their comments have been reflected in this final report.
13. At the end of the investigation stage, the investigator and clinical reviewer met with the Director to pass on their findings.

HMP PARC

14. HMP & YOI Parc is a category B local prison near Bridgend in Wales. It is a closed prison for prisoners who do not require maximum security, but for whom escape needs to be made very difficult. It holds approximately 1,200 male adults and young offenders. The prison opened in 1997 and is managed, under contract, by G4S on behalf of the National Offender Management Service (NOMS). At the time of the man's custody, healthcare services at Parc were provided by Primecare and included a 24 bed inpatient unit.
15. In June 2010, senior managers at G4S decided to terminate Primecare's contract at Parc and take responsibility for healthcare services into G4S. Managers explained that this was in line with the company's strategy of gradually bringing in-house the healthcare services in all their prisons. However, the process was brought forward at Parc after G4S managers concluded that Primecare's management of healthcare services was unsatisfactory. Primecare's contract ended on 27 September 2010.
16. Parc has also set up a Safer Custody Unit. (Many of the men in the former healthcare unit were subject to suicide and self-harm monitoring.) The ethos of this unit is to support prisoners in crisis and, by a multi disciplinary approach, return them to normal location with ongoing support. The unit is staffed by Prison Custody Officers (PCOs) with training in suicide and self-harm prevention.

HM Inspectorate of Prisons (HMIP) report

17. When HMIP inspected Parc in September 2010, they were highly critical of the healthcare services. The report said that healthcare services "were not delivered to an acceptable standard" and concluded, "Prisoners did not have access to NHS health services equal to those found in the community". Shortly afterwards, the Director, in consultation with the Regional Offender Manager (now Deputy Director of Custody and Probation, Wales), decided to close the inpatient unit.
18. Parc has now adopted a community based nursing model with nurses seeing offenders on their units and triage (assessing priority) is carried out there. The doctors carry out a primary care role and are trying out holding general practitioner (GP) clinics in the treatment rooms on the wings.

Glossary

Assessment, Care in Custody and Teamwork (ACCT)

19. ACCT has been introduced at all prisons to monitor and support prisoners assessed as at risk of suicide or self harm. Once placed on

ACCT, the prisoner will be subject to regular case reviews that will direct observations/conversations to be carried out at intervals determined by their perceived level of risk. The observations continue during the day and the night.

Defibrillator

20. The defibrillator is a machine that treats victims of sudden cardiac arrest by delivering a shock to the heart.

Listeners

21. Listeners support prisoners who may be at risk of suicide and/or self-harm. They are trained, selected and supported by Samaritans to offer confidential emotional support, 24 hours a day, to fellow prisoners in distress.
22. The Samaritans phone is a wireless handset that connects only to the Samaritans helpline which prisoners can use in their cell.

Cut-down tools

23. Cut-down tools are used to cut ligatures. All staff in closed and semi-open prisons who have contact with prisoners must be provided with and carry, when on duty, their own personal issue tool. They contain a concealed blade in the mouth section which is designed to allow the user to get underneath the ligature. The action of pushing the knife forward cuts the ligature.

Counselling, Assessment, Referral, Advice and Throughcare services (CARATS)

24. Organisations specialising in the treatment of substance abuse have drugs and alcohol workers based in most prisons. CARATs workers can run programmes, offer counselling, support and referral to rehabilitation centres to prisoners and on release. Access to CARATs is voluntary, by application.

KEY EVENTS

25. The man was convicted of robbery on 11 May 2007 and given a sentence of Imprisonment for Public Protection (IPP) with a tariff of two years and 145 days. (IPP prisoners have no automatic right to release at the end of their sentence but must demonstrate to the Parole Board that their risk to the public is acceptable.)
26. Before being imprisoned the man had been examined by psychiatrists and two reports had recommended that he be admitted to a psychiatric hospital under the provisions of the Mental Health Act 1983. However, that did not happen. He had harmed himself a number of times whilst in prison, during this and previous sentences, including attempted hanging in 2000 and 2006 and trying to cut his throat in 2008.
27. By 2008, the man was at HMP High Down. A referral letter written by the inpatient manager at the prison gave a medical history and his opinion of his behaviour:

“I suspect that he will seek the comfort of the Healthcare unit when he arrives with you ... You will need to carefully assess any symptoms and manage accordingly. Please be aware though that he does self-harm from time to time, and I have known him to engage in very risky behaviour, such as hanging, when he feels it is necessary.”
28. The man served his sentence in a number of prisons before arriving at HMP Littlehey in February 2009. At a hearing on 27 April 2010, the Parole Board did not recommend his release or transfer to an open prison. His offender supervisor had recommended that he repeat the Rehabilitation for Addicted Prisoners Trust (RAPt) drug course. (The offender supervisor's role is to assist a prisoner in carrying out the sentence plan of offending behaviour work set by his probation officer or offender manager.) The Board stated that they would like him to repeat the drugs course and spend some time in a therapeutic community.
29. The man's CARATs worker liaised with agencies in the community and obtained funding for him to take part in a drugs programme when he was released. She told my investigator that this would have satisfied the requirement to spend time in a therapeutic community. When the investigator asked why he should complete another drugs course, she suggested that it might have been to give him additional strategies to deal with his addiction.
30. P-ASRO (Prisoners - Addressing Substance Related Offending) is the name of an intervention delivered to offenders in custody whose substance use means they are more likely to commit crime. It looks at issues such as harm-reduction strategies. The RAPt - 12 Step Programme is longer and focuses on abstinence.

31. Whilst at Littlehey, the man was bullied after falling into debt to other prisoners. My investigator spoke to the Head of Operations and Security at Littlehey. He said that the man ran up the debt buying drugs. For his own safety, staff moved him to the segregation unit (in some prisons this is known as the care and separation unit), where he spent some weeks. In many male prisons, men who get into debt can move to the vulnerable prisoners' unit (VPU). However, Littlehey is a fully integrated prison and does not have a VPU, so that was not an option for him.
32. Staff tried to arrange a transfer for the man, suggesting a number of prisons to him. The Head said that he turned down their suggestions, saying he would have the same problems in those prisons. In turn, he kept suggesting Parc and moving there to do a drugs course. Wing staff at Littlehey remember him asking to move to be closer to his family. The Head of Operations and Security spoke to the Controller at Parc, and arranged a transfer for him.

Transfer to HMP Parc

33. On 5 August, the man transferred to HMP Parc and went through the reception procedures. In the form titled "Transfer in Checklist", the section on mental health problems lists paranoia and depression with the statement "No longer problem". The section on risk to self notes him as having a history of self-harm but no current suicidal ideas or self-harm. To the question, "Is he showing signs of acute distress (paranoia, hearing voices, acute anxiety, despair etc)" the answer was no. He then went to the induction unit on A wing.
34. The following day, one of the chaplains spoke to him before making an entry in the wing history booklet. (This booklet is kept on the wing and is available for all staff to read and make notes in.)

"...He informed me that he has a history of depression, self-harm and suicide. Had been on medication from 2001 till 2 years ago when he removed himself off the meds. This was also around the time of his last suicide attempt. He reported that he still has paranoid thoughts and suicidal thoughts but has not followed them through recently."
35. There are no entries in his prison or medical records for the next five days. However, the man's family told my family liaison officer that his positive attitude to being at Parc quickly gave way to disappointment at what he saw as a backward step. He told them that he had made a mistake by moving, and this distressed him.
36. On 11 August, a member of staff interviewed the man as part of the offender management procedures. (The prison managers were unable to give any information about this member of staff, other than she no

longer worked at the prison. My investigator therefore could not interview her.) She was clearly concerned about his state of mind as she wrote in his record, "He reports being suicidal, paranoid and tells me the thoughts are keeping him awake at night."

37. She referred him to healthcare staff and opened an ACCT at 5.45pm. In the Concern and Keep Safe section of the form, she repeated the above information and then added:

"He has a history of suicide attempts by way of hanging while in custody and also by cutting his throat. When discussing the move to HMP Parc he tells me he is unhappy and feels he has made a mistake. He also stated that he feels the paranoia has returned and would like some intervention with this as it is becoming unmanageable."

38. When it was time for the prisoners to go to their cells for the night, the man spoke to one of the Prison Custody Officers (PCO). She wrote in the ACCT that he threatened not to go into his cell as he wanted to go to the care and separation Unit (CSU) to "get his head together". She said that she would speak to the healthcare staff to "get him some help and support." She then asked a Registered Mental Nurse (RMN) to speak to him and consider "the possibility of a respite period in the H/C [healthcare centre]."
39. Nurse A interviewed the man. He told her that he did not know what was wrong with him except that he could not cope around other people and felt unsettled having moved prison. He asked to go to the CSU as he felt calm there. However, when she asked him if he would be prepared to go to the inpatient unit of the healthcare centre for respite and a mental health assessment, he agreed.
40. The nurse arranged an appointment with another RMN for further assessment the following day. She also made a note to contact Littlehey to check why a scheduled psychiatric review had not taken place before the man's transfer. She then escorted him to the inpatient unit, where he was admitted at 8.40pm and put in cell 13. A note in his medical records stated that he appeared to settle in quickly. He turned off his television early and slept through the night.

Inpatient unit

41. On 12 August, the observations in the ACCT show that the man had a quiet morning and mixed well with the other prisoners on the unit. He had a meeting with a senior nurse, who is also an ACCT assessor and who asked him about his problems. Nurse B said that the man felt paranoid and thought that people were talking about him. Although he had coped with such feelings in the past, he could not manage at present. The nurse wrote that the man said he "has no future and cannot see a way out." However, he said that he did not want to be

dead and felt happier being in the healthcare unit. The nurse and the man agreed that he should remain in the inpatient unit until he was examined by a psychiatrist and that he would be referred to the mental health in-reach team. The nurse also completed the inpatient unit admission form and care plan for him, including the goal, "To maintain safety and provide coping mechanisms."

42. Later that day, Nurse C from the Primary Care Team carried out a full mental health assessment. The man repeated a lot of the information he had given Nurse A the day before. However, he also said that he started feeling paranoid and unable to cope whilst at Littlehey and had refused to speak with the psychiatrist. He said that he had no thoughts of suicide and had good support from his family. He wanted to be prescribed medication rather than relying on illicit drugs to "take away his feelings".
43. In the section on needs, Nurse C wrote that an in-reach referral was necessary. However, she left the section on agreed action plan blank. She told the investigator and clinical reviewer that this was because she needed to discuss the issues with colleagues before deciding on an action plan.
44. Several of the ACCT and medical record entries for 13 August describe the man as "settled". However, a rather contradictory entry at 6.30 pm stated, "Generally settled today – gave his TV to staff as he felt stressed out and thought he might smash it".
45. There is nothing in the records to show that staff did anything other than remove the television from his cell. This is pertinent given that the care plan goal was "to provide coping mechanisms".
46. At 11.40 pm, the staff discovered that the man had cut his arm. Then, when a Healthcare Assistant (HCA) A spoke to him, he gave her strips of torn bed linen that he had thought of using as a ligature. He spoke to Nurse D and told him that there was no point in living. An entry in the ACCT document suggests that he treated the cut to his arm himself. It said, "He asked for something with which to clean and dress his wound, which he was given".
47. Staff moved the man into a cell fitted with a camera, although he had said he would not like people watching him all the time. Staff explained that it was to ensure his safety but he described it as a "punishment". Once in the cell, he paced up and down and banged his head several times against the window bars. He went to bed but then got up and used wet toilet paper to cover the camera lens. Staff asked him to clear the lens, which he eventually did. After getting into bed again, he went to sleep.
48. As the man had cut his arm, Nurse B held an ACCT case review the following afternoon (14 August). He told staff he felt stressed and

paranoid and had difficulty coping. However, he also said that he now felt better and had no further thoughts of self-harm. The people at the review meeting decided not to increase the frequency of the conversations. As he remained in one of the camera cells, staff in the office could check on him on the CCTV monitor. He took part in association (the period when prisoners are out of their cells and can associate with each other) in the afternoon and mixed well with the other prisoners. However, HCA B described him as “a little more distant and quieter”.

49. On 16 August, A PCO, one of the prison drugs workers held a meeting with the man, after he received his CARATs file from Littlehey. They discussed what work he needed to complete in order to get parole at his next hearing. The PCO said to my investigator:

“After I received his file I explained to him the reason why he had been sent to Parc was to complete the PASRO and he was quite surprised by this, the fact that he’d been sent here to do PASRO when he’d completed the 12 Step programme. He’d seen it as a backward step.”

50. The PCO asked the man to sign a service withdrawal form to show that he did not want to work with CARATs at that time. He explained to my investigator that this meant that he had a duty to return to the man in a month’s time and discuss whether he wanted to engage with CARATs then. He put the date of 13 September in his diary to speak again with him.

51. The following day, one of the chaplains wrote a detailed entry in the ACCT plan after he had spoken to the man:

“Quite low this morning. States that he wants to have counsel (sic) re his suicidal thoughts which are constantly there. States that authorities see drugs as the main issue but for him this is secondary to suicidal thoughts. In-reach team to assess this week.”

52. Later that day, the man moved from Cell 9 to Cell 6, which was not a camera cell. There is no explanation of the reason for this in the records. However, during the interview with Nurse B, he said that three cells, including Cell 9 were set aside for young offenders, although they could sometimes be used for adult prisoners if necessary. Again, when he moved to a non-camera cell, there is no evidence that staff considered increasing the level of observations of, and conversations with, him.

53. On 18 August, there was a meeting of the in-reach team and primary care nurses. Unfortunately, the usual minute-taker was not present and there is no written record of what was discussed or how decisions were reached. The current Head of Healthcare was then a senior

nurse and she attended the meeting. My investigator asked her what she recalled of the meeting and she replied by email:

“I do recall attending a meeting to discuss patients to be seen by the visiting psychiatrist. He was discussed and as something had I think been mentioned about him possibly being transferred back to previous establishment as he had managed quite well on normal location there. The outcome was I believe that if this wasn't happening then he would be listed for the psychiatrist at the next clinic.”

54. This may explain why the man's medical record contained two versions of Nurse C's mental health assessment form. One has no action plan, as discussed above. However, the second copy has the following note added to the agreed action plan section, "He is due to be transferred back to Littlehey prison. If this does not happen for psychiatric assessment and plan".
55. There is no signature or date on this addition. My investigator could find no information about where the plan to return the man to Littlehey originated, nor a timescale for the transfer. So, he was not referred to a psychiatrist. The clinical reviewer interviewed the former Head of Healthcare at Parc when the man was there. She said that in her opinion, the decision that the In-reach team would not take his case was inappropriate and not based on the mental health assessment and other available information.
56. Over the next week, the entries in the medical records continue to describe the man as "settled". The entries in the ACCT are similar, in the main. The ACCT entries often say that he played pool with the other prisoners.

Family telephone call to the prison

57. On 23 August, the man telephoned his sister. As he spoke, she became more and more concerned about him and worried about what he might do. She telephoned the prison and the switchboard operator put her through to the Chaplaincy Department. One of the chaplains took the call and made notes as she spoke.
58. He told the investigator that she said that her brother had told her that he had "had enough" and made a point of asking her to look after their mother. He had done this in the past and then gone on to harm himself. The chaplain said that he would telephone the staff in the healthcare centre to pass on this information and he would then call her back.
59. The man's sister later told my family liaison officer that she had made the telephone call very fearful for her brother. She explained to the chaplain how he had tried to take his life before. However, as he was

on an ACCT then too and constant observation, staff had prevented his death. She also said,

“I held myself together for the sake of my brother to be strong for him as always. ... Before the phone call finished I asked to be called back and was then reassured that he was ok and being looked after as he was on the hospital wing.”

60. The chaplain told the other chaplains in the office about the concerns expressed by the man’s sister. One of them said that she had seen him that morning and she had not seen anything to concern her. Another chaplain said that he had just been in the inpatient unit where he had seen him playing pool and had no concerns about him. The chaplain telephoned the man’s sister to pass on this information.

61. He then rang the inpatient unit and spoke to Nurse E to pass on the concerns. He told my investigator:

“I shared that, you know, the message as best I could in making sure that she knew that an incident had happened before. He’d shared similar things to her [his sister] before and you know I suppose I would follow through you know could you make sure you see him.”

He did not make a note in the ACCT nor did he or any of the chaplains visit the man.

62. The warning from the man’s sister did not lead to additional support for, and closer supervision of, her brother. There is no record of the nurse acting on this information. As he was on an ACCT, she should have recorded it in the on-going record section, but she did not. Nor did she make an entry in his medical record. Given the information indicated that his risk of self-harm was raised, she should have acted to increase the support for him, but there is no evidence that she did anything.

63. The nurse later told managers that the chaplain had not made the message “significant enough”. She said that the chaplain had not told her that he was at risk of suicide, nor did he inform her of his request for his sister to look after their mother. She said that she had spoken to duty HCA C about the call and told her to “report any changes” in him. The HCA said that she “definitely” did not discuss the man with the nurse that day.

64. The HCA said that she spoke to the man before he was locked in his cell that evening. He had refused the “tea pack” and she tried to encourage him to eat, offering him a doughnut. She said that they had joked and that he told her he was not hungry but was fine. He was smiling as he spoke.

65. The fact that the information from the man's sister was not recorded in the ACCT or medical record meant that the staff who came on duty later in the day had no knowledge of it.

23/24 August 2010

66. Prisons operate at night with a reduced staff, this is known as night patrol state. At 8.30pm, the officers on night shift came on duty and at 10.00pm the prison went into night state. The unit manager was the night orderly officer (radio call sign Oscar 1), the most senior officer on duty in the prison. The wings were patrolled by officers and two additional security officers were available to assist as and when required.
67. During night patrol state, wing staff and nurses do not have access to keys allowing them free access around the prison and have to be escorted. At night, staff radios are on "open broadcast", which means that when one person talks, all staff hear the message. The officers are issued with a cell key in a sealed pouch for use in emergencies. They can also contact the control room by radio and ask the staff there to open a cell door electronically. The staff instructions are that during the night state, a cell may only be unlocked by a single member of staff where there is, or appears to be, immediate danger to life.
68. HCA A was on duty in the inpatient unit. PCO A was also in the unit, doing constant supervision of a prisoner. Constant supervision is where a prisoner is supervised by a designated member of staff on a one to one basis, remaining within eyesight at all times and within a suitable distance to be able to physically intervene quickly. (During the investigation, the HCA was on long-term sick leave, so my investigator was unable to interview her. The information about her actions came from prison records and information from other staff.) She checked the man twice an hour up to the midnight check. When she returned to his cell thirty minutes later, she saw him slumped on the floor, with a strip of bedsheet round his neck that was attached to the wall light above the toilet. She used her radio to call code red, to summon assistance from officers and the duty nurse. (Prison staff used codes to indicate an emergency. Blue indicates that a person has an injury that needs treatment and red that the person is non-responsive and it is an emergency. The codes allow the medical staff to respond with appropriate equipment.)
69. The two closest staff were two PCOs who were in the nearby care and separation unit. PCO B estimated that it took them less than a minute to get to the cell. PCO C looked through the observation hatch in the door and asked the control room staff to open the door. He then went in. He lifted the man as PCO A passed his cut-down tool to PCO B, who used it to cut through the strip of bedsheet. The officers then laid him on the floor and removed the sheeting from around his neck. PCO

Comment: What level of obs was he on at this point?

B checked the man's wrist and neck for a pulse. He did not feel one, so he and PCO C began cardio pulmonary resuscitation (CPR).

70. A nurse was in the outpatient part of the healthcare centre when he heard the code red call. He went through to the inpatient unit and collected the emergency equipment from the treatment room opposite the cell. Once the officers had laid him on the floor, he set up the defibrillator. The defibrillator assessed his condition and then instructed the staff to continue with Cardio Pulmonary Resuscitation (CPR, breaths and chest compressions). He and HCA A used an oxygen mask to put breaths into the man. The night orderly officer arrived and asked HCA A if the man was responding. When she said no, he told the control room staff to call an ambulance.
71. The staff carried on with CPR, taking turns so they could have rest periods. At 12.40am, the paramedics arrived and set up their equipment. They asked the staff to continue with CPR while they used it and administered drugs to the man. Sadly resuscitation was not successful and, at 1.09am, the paramedics declared that he had died.
72. The night orderly officer visited each wing to inform the staff individually of what had happened. He told staff to double the observations they were making on prisoners that night.
73. After a death, prison managers must hold a "hot debrief". This is a meeting of all the staff who were involved in finding and attempting to resuscitate the prisoner. The meeting should focus on reassurance, information sharing and how staff can support each other. Prison managers held a debrief in one of the healthcare rooms with the staff who had been involved in finding and attempted resuscitation of the man. The managers, including the Director, gave staff the rest of the night as well as the next night off and members of the care team offered their services.
74. Prison Service Order (PSO) 2710 Follow-up to a Death in Custody states that prison managers must inform the family "*as soon as possible in a suitable manner giving an accurate factual account of what has happened*". Because of the distance between the prison and the man's family home, the Director arranged for a family liaison officer (FLO) from a prison near their home to go and break the news. Afterwards, a chaplain, as well as one of Parc's FLOs, telephoned the family. The following day, they visited the family at their home. The Director and one of her staff later attended the funeral.
75. The Director offered to pay the funeral expenses. This is in line with PSO 2710. The PSO states that the prison should liaise with the funeral director and make payments directly, rather than through the family. However, when the funeral director could not contact staff at the prison, he telephoned the man's mother. This added to her

Comment: Did they offer expenses?

distress. Her son-in-law telephoned the prison but it was only at the third try that the person to whom he spoke resolved the problem.

ISSUES

Transfer from Littlehey to Parc

76. For some time before transferring to Parc, the man had been resident in the care and separation unit of Littlehey prison as a result of incurring drug debts. It is not acceptable for a prisoner to be in the segregation unit permanently because of its restricted regime. However, because Littlehey does not have a VPU, there was no alternative whilst he remained in the prison.
77. The Head of Security and Operations said that the man raised the possibility of going to Parc. Staff suggested other prisons but he said no, as he would have the same problems in those establishments. He said that he had relatives near Parc and he thought that he could do a drugs course there. I am satisfied that staff were correct to transfer him as it would allow him to return to a standard wing in a prison where he was not known. However, it would have been prudent for them to check that the required drugs course was available at that prison.

ACCT procedures

78. The ACCT is designed to give a prisoner the support he needs to help him through a period of crisis. An ACCT was opened for the man in a timely and appropriate way. The wing manager then completed the Immediate Action Plan section. He set the staff support as two conversations per day and two observations an hour. However, on the front of the booklet, the observations were written as "Two observations per day". In spite of this, the observations were carried out twice an hour; therefore I make no formal recommendation on this point. However, the Director may wish to remind staff to double check the accuracy of the requirements on the ACCT front page.
79. I am concerned to note that the frequency of conversations and observations remained the same throughout the man's time on the ACCT, set at two conversations per day. There is no evidence to show that staff ever considered increasing them. When he moved to a camera cell after self-harming, he may have been observed more frequently. Staff in the office were then able to watch him on the CCTV monitor. However, there is no record in the ACCT that laid out what level of observations was to be followed.
80. The man was admitted to the inpatient unit for respite care, which might have suggested that he needed increased support in terms of ACCT procedures as well as the change of location. Again, when he was moved from the camera cell to a standard healthcare cell, it would have been helpful for staff to consider whether to increase observations and conversations until they could assess how he was coping in the new cell. Staff should be reminded that ACCT plans are

evolving documents that must be updated as often as necessary to meet the needs of the prisoner.

81. The records show that staff observed the man twice per hour. G4S have "ACCT Observation Record" sheets added to the back of the ACCT and staff recorded their observations there. Almost always, the observations were done at 30 minute intervals. PSO 2700, Suicide Prevention and Self-Harm management does not state that checks must be irregular, as much will depend on the individual circumstances of the prisoner. However, regular checks can be used by someone contemplating harming themselves to work out how much time is available before the next check. Where checks and observations are regular, staff must ensure that this is because it is in the prisoner's best interests and not just for the convenience of staff.

The Director should ensure that staff are advised of the importance of deciding the frequency of ACCT checks and the benefits of making them irregular. The decisions should be recorded on the ACCT front cover.

The Director should ensure that ACCT case managers assess the prisoner's changing needs and adjust the levels of observations and conversations accordingly.

82. The man then moved to the inpatient unit and healthcare staff became responsible for maintaining the ACCT. The following day, Nurse B completed the ACCT assessment and the first case review meeting. He also completed the Caremap, which sets out the prisoner's issues and how they will be resolved. The nurse listed two issues – the man's personality disorder and being unable to cope on the unit [the normal wing]. The action for the first was to refer him to the in-reach team. For the second, the goal was "To assess to offer appropriate coping mechanisms" by providing "respite in Healthcare". There was no record of how he was to be assessed in this way and no mention of what coping mechanisms were being, or would be, considered. In the event, respite appeared to be regarded as an end in itself rather than as a means to an end.

The Director should ensure that staff are reminded that Caremap actions must be focussed on achieving the goals.

83. Staff then recorded their "conversations" with the man in the On-Going Record section of the ACCT. Some of the entries show that the member of staff had a conversation with him. However, too many of the entries merely describe his actions, such as the following on 15 August, "Settled morning on unit meals and association taken no new issues raised".
84. This entry, and others like it, begs the question of whether the man raised any *current* issues. During the investigation, my investigator

learned that there were significant staff shortages in healthcare while he was there. Staff described having too many duties to fit into a single shift. The staff in the inpatient unit had to make entries in the medical record as well as the ACCT and many of the entries are the same, suggesting that the one entry was used for both documents.

85. My investigator asked the staff she interviewed whether they had been trained in ACCT procedures and had they been taught the difference between observations and conversations. Some Primecare staff told her that they had not received ACCT training, whereas the G4S staff said that they had and knew what was required with regard to conversations. During the investigation, the investigator and clinical reviewer looked at other ACCTs that were open on that day. The quality of entries was better than those in his ACCT, showing that wing staff understood the difference between observations and conversations.

The Director should ensure that ACCT training for healthcare staff covers what a meaningful conversation is and how it should be recorded in the ACCT.

86. On 17 August, the man moved from the camera cell into a standard cell without a camera. The move is recorded in the ACCT plan but no reason is given. Neither is there any indication that staff considered what support he needed in returning to a regular cell. The clinical reviewer notes that the cell was not assessed for the risk of possible ligature points, given that he had made ligatures a few days earlier. She recommends:

The Director should initiate a review and risk assessment of ligature points in areas where there are patients identified as being at risk of self-harm or suicide.

Health

87. When the man transferred to the inpatient unit on 11 August, the healthcare services at Parc were provided by Primecare. However, prison managers had become increasingly concerned about the services provided and had given the company three months notice of the termination of the contract. My Investigator interviewed a number of current and past healthcare staff, who listed a number of serious issues.
88. The former healthcare manager at Parc whilst the man was there took up her post in June 2010 and resigned in September, before Primecare's contract ended. When interviewed by the clinical reviewer, she said there was:

“... a serious shortage of staff, she couldn't recall the exact nursing establishment, but clearly it was insufficient to manage a

24 hour service for up to 1,200 prisoners. So her immediate priority had been to try to establish an appropriate staff profile and to develop a more robust nurse recruitment and retention strategy. She had also identified the need to review the nurse training and development strategy to better reflect the patients and service needs.”

89. She considered that the nursing skills mix needed to be addressed as a matter of priority and wanted to ensure that more registered mental health nurses (RMNs) were available to undertake work with prisoners with mental health issues.

90. The current Healthcare manager was a senior nurse at Parc before her promotion. She said of staffing levels, from about March 2010:

“At that time it was horrendous. We were down to I think around ten nurses altogether so staffing levels should have been at six qualified nurses a day, we were often down to three, some days two. ... there was a lot of sickness, to be expected, working under that sort of pressure.”

91. She said that, while the senior nurses worked office hours, the other nurses worked “long shifts”. She explained they worked three 14-hour shifts a week, from 7.15 am to 9.15 pm. Because of staff shortages, nurses often worked through their break periods and some staff worked overtime to fill gaps in the roster. She also said that there was not a robust application process for a prisoner to see a doctor. Wing staff, in an effort to find out what was happening about a particular prisoner, were in the habit of ringing the inpatient unit nurse. This put additional strain on healthcare staff. She concluded:

“It was very frustrating knowing what a good healthcare looks like and what a good healthcare delivery looks like but not being able to do other than the bare essentials which was ensuring people got their medication, ensuring that new admissions were seen and screened and the people saw the doctor and it was very, very busy but there wasn’t an awful lot that was happening in healthcare terms.”

92. It was into this dysfunctional healthcare department that the man was admitted on 11 August. The clinical reviewer is very critical of the health services that were available for him. She concludes:

“The provision of care and treatment by Primecare Forensic Medical Services for the man was grossly inadequate, and that a culmination of circumstances leading to chaos and a crises within their Healthcare in-patient facility, led to a systematic failure to protect him from committing suicide, which our clinical reviewer believes was foreseeable and preventable.”

93. Many of the clinical reviewer's findings reflect the views of the inspectorate report and she makes 17 recommendations in her comprehensive and detailed review. The recommendations cover healthcare policies, procedures and organisation, staffing levels, staff training and development. I have not repeated all of them here but they are listed in Section 7 of the clinical review. The clinical review also makes detailed suggestions about mental health services and addresses self-harm strategies and assessing cells for ligature points. I discuss these issues below. I endorse all the clinical reviewer's recommendations.

Inpatient care

94. As the Head of Healthcare indicated, there was not much opportunity for staff to work with the men in the inpatient unit. The Observation record in the ACCT document notes what the man was doing at the time of each check. There was normally an hour of association in the morning and another hour in the afternoon, double that on one or two occasions. The rest of the time, staff noted that he was sitting or lying on his bed or watching television. For someone who was in the unit partly because he was "low in mood" that is a great deal of time on his own.
95. She said in her interview that when the unit was closed, a doctor assessed the men who were inpatients. Only one man needed nursing care. Nurse B said that most of the men were on open ACCT plans and he spent a large part of his shifts on the unit holding case reviews and carrying out assessments. It was the HCAs, the least qualified staff, who had most contact with the prisoners.
96. The clinical reviewer notes, "... he [the man] had not been offered any therapeutic interventions or meaningful occupational, social or recreational activities". She recommends:

The G4S Head of Medical Services should review the availability and diversity of therapeutic interventions and meaningful occupational, social and recreational activities for prisoners, to meet their assessed mental health needs.

97. The clinical reviewer highlights another consequence of the shortage of staff in the in-patient unit – the staff did not have the time to get to know their patients. This led to missed opportunities to notice behaviour that might have indicated that the man was considering harming himself. She notes,

"Some of his behaviours, if he had had closer contact with mental health professionals, may have led them to suspect his suicidal intentions e.g. he had asked for help and counselling for his suicidal thoughts, he had self harmed and his sleep and eating patterns were disturbed . His family told the chaplain that

he had asked a Catholic priest for communion on Sunday the 22nd August, despite the fact he wasn't a Catholic (actually it was prison staff who told the family this, after his death); he was trying to give his property away to other prisoners..."

She concludes,

"Had this information been passed onto the mental health professionals it might have also informed an assessment of his suicide risk which could have been acted upon."

Mental health

98. The clinical reviewer notes that the man's treatment for his mental health conditions was not as good as that which he would have expected to receive in the community. She concludes:

"Had he been in the community, he could have expected to have had access to mental health services and treatment through his GP, possible further referral to a community mental health team, or admission to a place of safety detained under the Mental Health Act. He could have expected to have had ongoing assessment of his mental health needs, a full psychiatric and risk assessment, a review of his diagnosis, a treatment plan and as part of a care pathway, a risk management programme, which would have included the environment, for the potential risks he posed to himself. This approach would have reflected national frameworks and standards for mental health service provision."

99. After the RMN assessment on his admission to the inpatient unit, the man was referred to the in-reach team. At that time, referrals were discussed at a weekly meeting of primary healthcare staff (employed by Primecare) and in-reach staff (employed by Abertawe Bro Morgannwg University Health Board). His care was discussed at the meeting held on 18 August. The usual note-taker was not present so there are no minutes of the discussions.
100. The clinical reviewer and investigator asked the Head of Healthcare and the manager of the In-Reach Team what they recalled of the meeting. The manager of the In-Reach Team said:

“... that he was discussed as a possible new referral, but the Primecare staff informed the meeting that he was scheduled to return to HMP Littlehey imminently.”

The Head of Healthcare said the same. The manager of the In-Reach Team said that all discussions and decisions are now minuted.

101. There is no written record supporting the claim that the man was about to return to Littlehey and the investigation could not trace where the information came from. It would appear that after the meeting, someone noted on the RMN assessment form that if the transfer did not take place, he would be referred to the psychiatrist. The person making the note did not sign or date it and their identity remains unknown.
102. The former Head of Healthcare told the clinical reviewer that she did not attend the meeting. In her opinion, the decision about the man, “was inappropriate and had not been based on the review of the mental health assessment and other information available.” There is no record that healthcare staff referred him to a GP or that he was prescribed any medication.
103. The clinical reviewer makes the following recommendations.

The G4S Head of Medical Services is requested to;

Ensure the development and implementation of clear, measurable, clinical standards and protocols in mental health, reflecting national service frameworks, standards and guidelines.

Undertake a review of the various assessment and care records, with a view to their rationalisation and to consider the implementation of one multidisciplinary file for all prisoners requiring healthcare, to include a robust risk assessment process.

Review the prisons information and communications strategies to ensure; a robust clinical governance strategy, staff handovers between shifts, clearly minuted meetings with the MHIT and documented information relative to the Care Programme Approach meetings.

Undertake a review of the MHIT service provision and the psychiatric service from Caswell clinic, to include working arrangements, referral processes, timescales, communications and clinical governance arrangements.

Ensure the development of a care pathway process for all patients with assessed mental health needs, reflecting the national initiative, the Care Programme Approach (CPA).

Attempted resuscitation

104. When HCA A discovered the man at 12.30am, she called for assistance. Two PCOs who were working nearby went to the inpatient unit, as did the duty emergency healthcare nurse. The cell door was opened remotely by the control room officer at 12.32am and staff began CPR. A nurse attached the defibrillator and followed the machine's instructions. The paramedics arrived at 12.40 and took over the treatment. Sadly, he could not be resuscitated and paramedics pronounced his death at 1.09am. The clinical review concludes that the night duty staff "acted promptly and professionally"

Changes in Healthcare services since September 2010

105. Section 6.20 of the clinical review sets out the improvements that have been made since September 2010.

"HMP Parc have adopted a community based nursing model, whereby nurses see prisoners in their units and a Triage process (a systematic, evidence based assessment and identification of clinical needs) is undertaken there. GPs also carry out a primary care role and a trial of GP clinics has commenced.

"A more holistic approach to the management of self harming behaviours has already impacted on the service resulting in a reduction of incidents related to self harm and suicide.

"Mental health in- reach services continue to be provided by Abertawe Bro Morgannwg University Health Board and their service provision to HMP Parc is being reviewed by their new manager in discussion with G4s. They have already agreed a number of changes and improvements eg the MHIT is now based in HMP Parc, there are daily meetings between them and prison healthcare staff to review their patient case load, a clearer assessment and referral process is in place, there is a systematic care pathway for every patient and there are also plans to develop individual electronic multidisciplinary team records.

"There has also been a team building day held with G4S healthcare staff and the MHIT, where revised working arrangements, a review of expectations and raising standards of care have been discussed and actions agreed."

Lack of staff action in response to telephone call about the man's welfare

106. During the afternoon before the man's death, his sister telephoned the prison to let staff know of serious concerns about his wellbeing

following a telephone call that day. The chaplain did not go to the inpatients unit to visit him or to put the information in the ACCT.

107. When the chaplain passed the message from the family to Nurse E, she should have acted on the information. She could have done a number of things to put additional support in place for the man, as part of either the suicide prevention and self-harm management procedures or a clinical process, but she did not. This was a serious failing in a situation where it was clear that intervention was necessary, potentially to save a life.
108. After the man's death, the Director developed a new procedure for when families telephone the prison with information about their relative. Now, in addition to passing the information to the wing staff, the chaplain taking the call must also tell the safer custody officer. The safer custody staff will then follow up to check what action has been taken. The chaplain must also note the telephone call in the chaplaincy log. If the prisoner is on an ACCT, the chaplain must make a note in the ACCT and offer to visit him within 24 hours.
109. In addition, all staff, including chaplains, will receive annual training in mental health awareness. In the light of these improvements, I do not make any recommendations. The improvements are commendable, but they do not diminish the tragedy of the missed opportunity for the man.
110. Nurse E was suspended pending an investigation. She transferred to G4S with the other healthcare staff. In March, at a disciplinary hearing, which she did not attend, her contract of employment was terminated. The internal G4S investigation conducted before her disciplinary hearing identified a number of issues and recommended improvements. My investigator received a copy of the report and noted that all 15 recommendations had been accepted.

Funeral costs

111. The Director offered to pay the funeral expenses. This is in line with PSO 2710, Follow-up to a Death in Custody. The PSO states that the prison should liaise with the funeral director and make payments directly, rather than through the family. However, at the beginning of November, the funeral director rang the man's mother saying the bill, or part of it, was outstanding. Her son-in-law called the prison three times, speaking to a different person each time. After two apparently fruitless requests that the matter be attended to, a duty manager resolved the issue with the funeral director. The duty manager later explained to the family that the funeral director had emailed various people at the prison without getting a reply.

The Director should ensure that in future a named point of contact (and back-up) is appointed to liaise with the funeral director and for the contact details to be put in writing to the funeral director.

CONCLUSION

112. The man arrived at Parc feeling positive about the transfer. He thought it would move him towards his release from prison. Within a week, his mood had plummeted as he concluded that it was a step backwards and had been a mistake. Staff opened an ACCT plan and admitted him to the inpatient unit for respite.
113. Unfortunately, healthcare services, including the inpatient unit was in crisis. Staff shortages leading to overworked and stressed nurses had a serious and negative impact on the welfare and treatment of patients. The man did not receive the same standard of care and treatment that he could have expected to be available to him in the community.
114. Regrettably, in spite of a very clear and urgent warning from the man's sister, staff failed realise his risk of self-harm had increased. He did not get the additional support he should have been given on receipt of this information and was found dead only hours after his sister's alert.
115. Since then, the Director has implemented a programme of changes and G4S now run the healthcare services. While I acknowledge and applaud the Director's response and the consequent improvements, I cannot help but express dismay that they all came too late for the man. Staff had the opportunity to intervene and provide additional monitoring and support at a crucial time and failed to do so. I am sorry that this has led to a death which could feasibly have been prevented.

RECOMMENDATIONS

1. The Director should ensure that staff are advised of the importance of deciding the frequency of ACCT checks and the benefits of making them irregular. The decisions should be recorded on the ACCT front cover.

The recommendation was accepted. The response was,

“This will be reinforced with all managers who are accountable for deciding the frequency of ACCT checks and the importance of recording decisions on front of the ACCT documentation. Written instructions will be provided to all managers and monitored via quarterly checks.”

2. The Director should ensure that ACCT case managers assess the prisoner’s changing needs and adjust the levels of observations and conversations accordingly.

The recommendation was accepted. The response was,

“A programme of training will be provided to all Operational Managers to ensure they are fully aware.”

3. The Director should ensure that staff are reminded that Caremap actions must be focussed on achieving the goals.

The recommendation was accepted. The response was,

“Caremap training will be provided to all Operational Managers to ensure they fully understand the importance of achieving the goals.”

4. The Director should ensure that ACCT training for healthcare staff covers what a meaningful conversation is and how it should be recorded in the ACCT plan.

The recommendation was accepted. The response was,

“A programme of training will be provided to Healthcare staff by the Safe Custody Managers.”

5. The Director should initiate a review and risk assessment of ligature points in areas where there are patients identified as being at risk of self-harm or suicide.

The recommendation was accepted. The response was,

“Additional in-cell CCTV has been installed in all cells on the Safe Custody Unit to improve observations for those considered to be at high risk. Those prisoners who are assessed as being at high risk will be located in a cell with CCTV coverage.”

6. The Director should ensure that in future a named point of contact (and back-up) is appointed to liaise with the funeral director and for the contact details to be put in writing to the funeral director.

The recommendation was accepted. The response was,

“This will become part of the role of the Family Liaison Officer; all FLOs have been informed and are aware. The back-up cover will be provided by the Director’s Personal Assistant.”

The G4S Head of Medical Services is requested to:

7. The G4s Head of Medical Services should review the availability and diversity of therapeutic interventions and meaningful occupational, social and recreational activities for prisoners, to meet their assessed mental health needs.

The recommendation was accepted. The response was,

“Negotiations in service delivery include the development of a Mental Health Day Care Centre to provide a setting which focuses on the therapeutic interventions. The area to house the centre has been identified and the appropriate furniture and fittings are being arranged.

“Additional funding for an increase to the existing Mental Health Occupational Therapist role has been agreed. Advertisement to be placed October 2011.”

Training in Therapeutic Interventions such as Stress Management and relaxation techniques are being provided by the Local Health Board (LHB), In Reach Team.

Talking therapies are currently in place with the Primary Mental Health Team.”

8. Ensure the development and implementation of clear, measurable, clinical standards and protocols in mental health, reflecting national service frameworks, standards and guidelines.

The recommendation was accepted. The response was,

“Standard Mental Health Assessment Tools have been adopted and are included in the Primary Care Teams clinical activity. These are measured by the quality indicators for Prison Health. These tools facilitate therapeutic activities, appropriate medication as assessed by the GP Services and referral on the appropriate Secondary Care Providers.”

9. Undertake a review of the various assessment and care records, with a view to their rationalisation and to consider the implementation of one multidisciplinary file for all prisoners requiring healthcare, to include a robust risk assessment process.

The recommendation was accepted. The response was,

“The implementation of the Electronic Patient Record System, SYSTEM 1, will resolve this issue. Go live date for the software is agreed as October 2011. This central electronic file will be maintained and owned by all clinical and non-clinical healthcare providers, whether primary, secondary or tertiary as a single and robust record.”

10. Review the prisons information and communications strategies to ensure; a robust clinical governance strategy, staff handovers between shifts, clearly minuted meetings with the MHIT and documented information relative to the Care Programme Approach meetings.

The recommendation was accepted. The response was,

“The Community Mental Health InReach Team (CMHIRT) are now located with Healthcare inside the prison. Weekly internal meetings are held and monthly board meetings with senior managers from the external MHIRT take place. The meetings share the assessments and plans for those referred to InReach providers.

Further meetings will be held to review and update the single referral pathway. The CMHIRT attend HMP Parc’s clinical governance meetings and are now invited to our medicines management committee meetings.”

11. Undertake a review of the MHIT service provision and the psychiatric service from Caswell clinic, to include working arrangements, referral processes, timescales, communications and clinical governance arrangements.

The recommendation was accepted. The response was,

“The review is already underway. A project team consisting of HMP Parc, Abertawe Bro Morgannwg Health Authority and the CMHIRT has been set up and two meetings have taken place to date. A request has been made to the Welsh Assembly Government to increase the provision of the MHIT at Parc.

Referrals to the CMHIRT have increased from a weekly to daily provision and the CMHIRT maintain a daily diary of referrals and updates which is accessible to all healthcare staff.”

12. Ensure the development of a care pathway process for all patients with assessed mental health needs, reflecting the national initiative, the Care Programme Approach (CPA).

The recommendation was accepted. The response was,

“The Care Programme Approach is in place and the development and review of the pathway is part of the project remit as detailed above.”