

**Investigation into the circumstances surrounding the
death of a man at HMP Blakenhurst
in September 2007**

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

April 2009

This is a report into the circumstances of the death of a remand prisoner at HMP Blakenhurst, on 14 September 2007. An officer who unlocked the man for breakfast that morning discovered him suspended from the bunk bed and summoned assistance. Officers and healthcare staff attended, but the man had obviously died several hours previously and rigor mortis was present. Staff therefore did not attempt to resuscitate him. I offer my sincere sympathy and condolences to the man's family and friends for their loss. He was 43 years old.

The investigation was carried out by one of my colleagues. A clinical review of the man's healthcare at HMP Blakenhurst was undertaken on behalf of Worcestershire Primary Care Trust. I am grateful for this comprehensive review. I would also like to thank the then Acting Governor of Blakenhurst and his staff for their co-operation and assistance with this investigation. Particular thanks go to the liaison officer.

The man had suffered from mental health problems all his adult life and had made several attempts to harm himself in the community. In Blakenhurst, he came under the care of the recently established Forensic Liaison Team. The man had weekly or fortnightly appointments with members of the team, who provided a high level of individualised treatment and support.

In my reports into the deaths of the three prisoners in Blakenhurst in 2006, I made a number of recommendations. I am pleased that many of them have been implemented, leading to better procedures. Previously, I highlighted deficiencies in identifying new prisoners who needed mental health assessments and making the necessary referrals. I am pleased to note that the man's needs were identified during the reception health screen and he was promptly referred to the forensic liaison nurse. Family liaison procedures are also much improved.

However, I am disappointed to have to repeat a number of earlier recommendations. Of particular concern is that when self-harm monitoring was withdrawn from the man, a post-closure review did not take place. My investigator also found that night duty staff were still not clear on their role and responsibilities. I make four recommendations, primarily relating to these issues.

I must apologise for the length of time it has taken to issue this report.

Stephen Shaw CBE
Prisons and Probation Ombudsman

April 2009

CONTENTS

Summary	4
The investigation process	5
HMP Blakenhurst	7
Key findings	9
Issues	16
Recommendations	20

SUMMARY

The man was born on in October 1963 and died at the age of 43 on 14 September 2007 in HMP Blakenhurst. From his teenage years onwards, he had suffered from depression. This had sometimes been so severe as to require his admission to hospital.

On 13 April 2007, the man was charged with arson and remanded into custody to HMP Blakenhurst. Because of the charge he was facing, staff referred him to the Forensic Liaison Nurse. He was also allocated a single cell.

Over the next eight weeks, The Forensic Liaison Nurse met with the man several times. She referred him to the prison doctor, but the man would only discuss and be treated for his physical ailments. In June, the Forensic Liaison Nurse noted a deterioration in the man's mood and behaviour and again referred him to the doctor. The doctor prescribed a low dosage anti-depressant, designed to treat poor sleep rather than depression.

Three days after starting the medication, the man set fire to the television in his cell. The night staff discovered the fire and removed him from the cell. Healthcare staff who attended the man admitted him to the in-patients unit of the healthcare centre. They also opened an ACCT (Assessment, Care in Custody and Teamwork) plan to ensure that the man received the additional support he needed to see him through the period of crisis. He then went to the local hospital for a check up before returning to the healthcare centre.

The following day, the man was transferred to the segregation unit to await a disciplinary hearing for setting fire to his cell. On his second day there, the prison psychiatrist assessed him and readmitted him to the in-patients unit for observation. The disciplinary proceedings were then dropped.

Two weeks later (1 July 2007), the ACCT plan was closed. The following day, the man appeared in court where he was convicted and remanded for sentencing. He was very unsettled at having to wait to learn the terms of his sentence. He told the Forensic Liaison Nurse that he needed to know the length of time he had to serve before he could "see the light at the end of the tunnel". The man's mental health and behaviour continued to concern staff and he remained in the healthcare centre. His medication was increased but he continued to speak of the impending sentencing date.

Staff supervised a gradual discharge from the in-patients unit and the man moved back to Houseblock 6 on 15 July. At the beginning of September, he moved to Houseblock 1. The man told the Forensic Liaison Nurse on 4 September that he was settling into life on the new unit. He was attending an art class and hoped to attend a full-time art course. However, the man was still speaking of his next court appearance.

When an officer unlocked the man's cell at 7.30am on 14 September, he discovered the man slumped on the floor. He summoned assistance. The staff who examined

the man all agreed that he had died and, as rigor mortis had set in, they did not attempt to resuscitate him.

Prison staff visited the man's family to break the news. The prison's family liaison officers then provided help and support.

My report includes four recommendations.

THE INVESTIGATION PROCESS

1. The man died on 14 September 2007. My investigator opened the investigation two days later when she visited HMP Blakenhurst. She met the then acting Governor, a representative of the Prison Officers' Association, the Family Liaison Officer and the Forensic Liaison Nurse. She saw the man's cell on Houseblock 1 and was given copies of his prison records. My investigator returned twice more to Blakenhurst to conduct interviews with wing and healthcare staff.
2. One of my own Family Liaison Officers wrote to the man's family to ask if they had any concerns that they wanted to be included in the investigation. They asked why the man had been in a cell on his own, why staff had not removed his laces and whether he had been on 'suicide and self-harm watch'. I hope that this report goes some way to answering the family's questions.
3. A clinical review of the man's healthcare at HMP Blakenhurst was carried out on behalf of Worcestershire Primary Care Trust. I am most grateful for the comprehensive review.

HMP BLAKENHURST

4. HMP Blakenhurst is a local prison that serves courts in the West Midlands. Its population consists of both remand and sentenced prisoners. In 2006, Blakenhurst opened a new residential unit which increased the total number of prisoners it could accommodate to 1,070.
5. The Independent Monitoring Board's most recent report covers the period from 1 July 2005 to 30 June 2006. The report describes the prison as a "stable and well run establishment" although subject to national pressures due to the number of foreign national prisoners and those serving indeterminate sentences. The healthcare provision is described as being improved, although staffing shortages are noted. The report draws attention to healthcare staff winning a national award from the National Institute for Mental Health in England for innovative practice in prison healthcare units. The areas on which they were judged included the work of Community Psychiatric Nurses (CPNs) on the wings, improvements in mental health care in the segregation unit, and the provision of a consultant psychologist with a full supporting team.
6. The most recent inspection by HM Chief Inspector of Prisons, Ms Anne Owers, was unannounced and carried out at the end of 2005. Ms Owers recognised that, "Blakenhurst operates within a very tight budget, and with very light staffing levels". She suggested that "mental health provision was particularly good" in the healthcare department. Ms Owers found that the substance misuse team "provided a generally good service", although "alcohol abuse provision was restricted to detoxification and weekly Alcoholics Anonymous meetings".
7. At the time of Ms Owers's inspection, Blakenhurst had identified suicide and self-harm prevention as an absolute priority following seven self-inflicted deaths between the start of 2003 and July 2004. The Safer Custody team was reported to be well-resourced and represented at a senior level in the prison. This is still the case. There were no self-inflicted deaths at Blakenhurst in 2005, but three in 2006.

KEY FINDINGS

8. On 13 April 2007, the man was charged with arson with intent and transferred from police custody to Magistrates' Court. The Prisoner Escort Record (PER) that accompanied him flagged up that he was at risk. A note on the form said that he had a "suicidal the marker on PNC [Police National Computer]". At 10.10am, he was remanded in custody until 23 April to appear at the Crown Court. Immediately after he returned to the court cells, he was interviewed by a community psychiatric nurse (CPN) who then placed him on a 15 minute watch. From court, he went to HMP Blakenhurst. The CPN completed a suicide self-harm warning form that accompanied the man to prison. On it she noted that he was being treated by a psychiatrist in the community. In addition to "numerous attempts to self-harm", she flagged up a serious alcohol problem.
9. As part of the reception process, the man was interviewed by a nurse who completed a First Reception Health Screen form. The man told the nurse that he suffered from depression and had received both medication and hospital treatment as a result. He said that he misused alcohol and described drinking six litres in one session. He also said that he had tried to hang himself in 2006 in the community. However, the nurse noted that he appeared cheerful and recorded, "States no immediate plan/intent." The nurse then referred the man to a doctor for the alcohol problem and for a mental health assessment.
10. After going through the reception procedure, the man moved to the Induction Unit on Houseblock (HB) 6. The officer and nurse who interviewed him in order to complete the Cell Sharing Risk Assessment (CSRA) assessed the possible risk to a cellmate as high because of the charge against him. He was therefore allocated a single cell throughout his time in Blakenhurst.
11. The following day, the man attended the healthcare centre as he was suffering from the effects of alcohol withdrawal. Staff prescribed a detoxification programme of chlordiazepine and vitamins.
12. In view of the charge the man was facing, the reception nurse also referred him to the Forensic Liaison Nurse. The post of Forensic Liaison Nurse was established in April 2007 to offer additional support to men facing serious charges. The Forensic Liaison Nurse does not carry out standard nursing duties but supports the 15-20 patients in her caseload. Most prisoners are referred to her by reception staff as they see the charges facing each new arrival. However, any member of staff can make a referral. Each new patient is discussed at a referral meeting. The Forensic Liaison Nurse then has an initial meeting with the prisoner during which she assesses his mental health and needs. Where necessary, she refers men to the prison's general practitioner or directly to the psychiatrist.
13. The Forensic Liaison Nurse first tried to see the man on 19 April but he was at the gym. She tried again on 23 April when he was at the library. Four days later, she met him on HB 6 and carried out the mental health assessment. The Forensic Liaison Nurse told my investigator that she was not overly concerned that her first meeting took place two weeks after the man's arrival at Blakenhurst.

She said that she felt that his attendance at the gym and library was a positive sign that he was keeping occupied. In addition, no member of staff had felt it necessary to refer the man to her in the interim.

14. At their first meeting, the man told the Forensic Liaison Nurse that his appetite was fine but his sleep and concentration were poor. His replies to her questions were considered, although sometimes rather vague because his memory was “a bit patchy”. He described himself as being a 4 or 5 on a happiness scale of one to ten. He agreed to talk to the prison doctor about medication, although he stressed that he felt that anti-depressants had not helped him in the past. The Forensic Liaison Nurse arranged a follow-up visit for 14 May.
15. The man had given the Forensic Liaison Nurse contact details for his social worker and the Nurse faxed her afterwards to ask for any information she might have. The social worker responded on 1 May. The social worker said that the man had not been receiving any medication in the community, nor had he been showing any signs of thought disorder. She also described the events that had led to the man’s arrest and stressed the seriousness of his actions.
16. The Forensic Liaison Nurse also made a doctor’s appointment for the man which he attended on 30 April. However, the man was more concerned about problems with his feet and knee than anti-depressant medication. The doctor referred him to the chiropodist and physiotherapist for treatment but did not prescribe anti-depressants.
17. On 14 May, the Forensic Liaison Nurse visited the man in his cell, where he was watching television. As they walked to an interview room, the man chatted easily. The Forensic Liaison Nurse noted that he appeared settled and there was no evidence of low mood or mental illness. He did not mention any thoughts of self-harm either. He told her that, earlier in the day, he had been assessed by a psychiatrist who was preparing a report for the court.
18. The man started to attend Saturday morning art classes in the education block. My investigator spoke to his teacher. She described him as a very quiet man. She said that he worked happily on his own and produced large-scale surrealist drawings done in felt-tipped pens. Another prisoner was friendly with the man and they sat together.
19. The Forensic Liaison Nurse’s next appointment with the man was on 6 June. She was struck by the very marked change in him. He looked “unkempt and dishevelled” and it was obvious to her that he was not taking care of himself. He told the Forensic Liaison Nurse that he was “drained” and was sleeping very badly. During the appointment he occasionally laughed inappropriately, although he denied he was hearing voices. The Forensic Liaison Nurse again referred him to the doctor to consider anti-depressant medication.
20. When the man consulted the doctor two days later, he again described some physical ailments for which he was prescribed medication. The doctor also prescribed a 14-day course of mirtazapine, an anti-depressant. The dosage was

very low, designed more to treat poor sleep than depression. Over the next few days the man took the medication, although not on 11 June.

21. At 11.10pm on 11 June, the night orderly officer was passing the man's cell when he realised that it was on fire. The man had wrapped a towel round the television set and then set it alight. The night orderly officer and the Operational Support Grade (OSG) on duty took the man out of the cell and called for the fire brigade and healthcare staff to attend. The man told the staff that he had set fire to the cell because he did not like the food he had been given. It was recorded that he smiled as he said this. It was estimated that the fire had caused £1,200 worth of damage and the man was placed on a disciplinary charge. (When a prisoner is believed to be in breach of a Prison Rule, he can be placed "on report". A disciplinary hearing, called an adjudication, is then held.)
22. The healthcare staff admitted the man to the in-patients ward of the healthcare centre as he was suffering from smoke inhalation. He was also coughing up black sputum. The man told healthcare staff that he had set fire to his cell because he had nothing left to live for. A staff nurse therefore opened an ACCT plan at 12.50am. (An ACCT document describes the problems facing a prisoner at risk of harming himself and implements a plan to give the support he needs to help him through a period of crisis.) The staff nurse wrote in the ACCT that the man felt very depressed and wanted to die.
23. At approximately 1.30am, the man was taken to the Accident and Emergency Unit at the Alexandra Hospital in Redditch. Hospital staff x-rayed and assessed the man and he then returned to the healthcare centre at about 4.00am. The officers who accompanied the man to hospital told healthcare staff that the hospital had advised them to keep the man under observation for the next 24 hours.
24. Once an ACCT plan is opened, a trained assessor must interview and assess the prisoner. A second staff nurse met the man to complete the assessment. The man said that he did not want to die and did not have any thoughts of self-harm. He also said that he could not remember the events of the previous night. The first case review meeting then took place. The man and the two staff decided to keep the ACCT plan open and arranged the next review for 19 June.
25. Later that day, one of the general nurses spoke with the man about setting fire to his cell. He told this nurse that he did it because of "other inmates having a fracas with him". The man had, therefore, given members of staff three different explanations for his actions on the night of 11 June. Staff then assessed the man as being fit to return to the houseblock.
26. However, that afternoon, rather than returning to the houseblock, the man was moved to the segregation unit to await the adjudication hearing for setting fire to his cell. His medical records show that healthcare staff visited him there on 13 and 14 June and state, "No concerns/issues raised." The man remained on the ACCT plan during his time in the segregation unit.

27. On 13 June, the charge nurse, the team leader in lower medical (the in-patient ward), carried out a psychiatric assessment on the man. He told her that he did not remember setting fire to his cell and he had not been hearing voices. He said that he had begun to wake early and then felt tired because of this. He felt depressed and hungry all the time. The charge nurse noted that the man appeared low in mood. She instructed staff to continue the general observations. She also said that staff should monitor the man's blood sugar because of his feelings of hunger.
28. The charge nurse referred the man to the Forensic Liaison Nurse and put him on the list for discussion at the multi-disciplinary meeting scheduled for 15 June. From then on, the man was regularly monitored by the team during their weekly meetings. The team is led by a psychiatrist, and includes the Forensic Liaison Nurse, discipline staff and psychologists.
29. The psychiatrist and his team visited the man in the segregation unit on 15 June and completed a full mental health assessment. This included a suicide indicator assessment on which the man scored 54 out of 72. The clinical reviewer has commented on this in his report and says that, at the best of times, the man's score would have been 40. The psychiatrist's team concluded that he was suffering from mild depression associated with recent family stress and alcohol issues. The psychiatrist increased the mirtazapine prescription to 30mg, the lowest dose used to treat depression. He also readmitted the man to the inpatients unit in the healthcare centre for one week for further assessment. The man's adjudication hearing took place and the duty governor referred the matter to the police and for legal advice. In practice, no further action was taken.
30. From the notes in his medical record and the observations made in the ACCT, it seems the man settled well into the inpatients unit. His sleep improved, as did his personal care. He did not interact much with others but staff concluded that his personality did not lead him to mix easily with other people. The Forensic Liaison Nurse visited him on 18 June and for the first time he spoke about outside interests. He told her that he felt the medication was helping to lift his mood, and spoke positively about his brother's recent visit. However, when the Forensic Liaison Nurse asked him whether he had thoughts of self-harm, he replied, "Sometimes." However, he then went on to say that he "couldn't be bothered".
31. After the initial seven day assessment in healthcare, the man did not return to the houseblock but remained in healthcare. At the ACCT review on 21 June, the man said that his medication was helping him and there were no side effects. However, four days later his mood dipped once more. Staff noted that he was associating even less than usual with the other prisoners and he stayed in his cell. He also blocked the observation hatch in his cell door.
32. Eight days later, however, when the psychiatrist reviewed the man, he noted that he had improved once more. He decided that the man could be discharged and returned to the houseblock. The plan was to reintegrate him gradually, rather than an immediate return.

33. The ACCT plan was closed on 1 July. The man told the staff that he was now positive about his future and was happy with his medication. He had no thoughts of self-harm and agreed to accept support once he returned to the houseblock. He was content with the plan to gradually discharge him from the healthcare centre. A post closure interview should have been arranged to enable staff to check on the man's progress after the ACCT was closed, but this was not done.
34. The man returned to court the following day, and was convicted and remanded in custody until sentencing. The next day, healthcare staff noted in the man's record that he was concerned about his appearance in court as he had not been able to hear what was said properly. Staff explained that he had been remanded to await sentencing and noted that the man appeared angry at the three week delay. He refused his evening medication that night and also on 4 July. A further entry the following day described the man as being unkempt and displaying inappropriate behaviour. He had written on his cell wall, "The devil is here." Staff did not re-open the ACCT plan but persuaded the man to start taking his medication again.
35. The man was assessed using the Hospital Anxiety and Depression Score. He was marked at 10 for depression, which is borderline, and 18 for anxiety, which is significant. He began taking his medication again. Two days later, the psychiatrist reviewed the man once more and noted that, although not severely depressed, he was agitated. In addition to the mirtazapine, he also prescribed an anti-psychotic, olanzapine. Anti-psychotic medication is prescribed for psychosis and sometimes for anxiety, in very low doses.
36. The Forensic Liaison Nurse visited him on 9 July and noted that he was "low in mood at times". The man attributed this to the court case and not knowing how long his sentence would be. He said to The Forensic Liaison Nurse, "If I could get to know what I was having, what I was serving, I'd know where I was heading and the light at the end of the tunnel." He agreed that his medication was helping and said that he would continue to take it. He also said that he was completing education worksheets and that helped to keep him occupied. However, he added that he was sometimes bored.
37. By the time the psychiatrist next assessed the man on 13 July, he was requesting to return to Houseblock 6. The psychiatrist noted that the man was "currently mentally well without any major depressive symptoms". He agreed that the man could leave healthcare and arranged regular follow up appointments with the mental health team. Two days later, almost five weeks after the cell fire, the man was discharged from healthcare and returned to the houseblock.
38. On 17 July, the Forensic Liaison Nurse visited the man and noted that he engaged well with her. He was well-kempt and expressed no thoughts of self-harm. He was unemployed but wanted to start education classes, particularly art. He had lost his prison identity card and said that, as a result, he could not collect his medication. The Forensic Liaison Nurse spoke to the officers on the houseblock and the man obtained a replacement card. He then took his medications regularly until the beginning of August. On 10 August, he told the Forensic Liaison Nurse that he had felt so much better by then that he had

stopped taking his medications for a few days. However, he had noticed a difference and decided to begin taking them again.

39. The man had a doctor's appointment on 29 August as he had chest pain. The doctor prescribed medication for a chest infection. Later that day, the man told the general nurses in the presence of the Forensic Liaison Nurse that he was unable to catch his breath. This was diagnosed as a panic attack rather than being due to the chest infection.
40. At the beginning of September, the man moved to Houseblock 1. There he met a prisoner he had become friendly with during the art lessons. The man's friend asked the teacher if the man could begin art classes again. She agreed and the man resumed Saturday morning sessions. The teacher then moved the man to the afternoon class as it was for advanced learners and she judged that it better suited his abilities. The man and his friend met most days to chat and have a smoke.
41. The Forensic Liaison Nurse met the man on the afternoon of 4 September. He told her that he was slowly settling in to the new houseblock and that he had started art education, which he enjoyed. He said that he was still waiting for a court date and continued to feel apprehensive about it. He looked forward to knowing the length of his sentence. That was the last time the Forensic Liaison Nurse met the man, as the next appointment was due to take place on 28 September.
42. On 13 September, the man had an appointment with a counsellor from Relate, an organisation that provides counselling and other relationship support services. My investigator spoke briefly to the Relate counsellor but did not interview him as the consultations are confidential. The counsellor did, however, say that the man was concerned about returning to court for sentencing the following week. The man also spoke to his friend about this matter. The man's friend told my investigator that the man said he was back in court on Monday and was "looking at two years". They talked about asking staff if they could share a cell but the man had said that his snoring would keep his friend awake all night. He then added that he would be all right and would stay where he was.

14 September

43. Towards the end of the night shift, staff should conduct a roll check. As well as counting the number of prisoners on their houseblock, the staff should also check each prisoner's wellbeing. An OSG did not carry out the roll check. She told my investigator that her understanding was that she only needed to check prisoners on ACCTs and other watch lists. She used the total for the evening roll check to complete the night duty roll.
44. At 7.30am, two officers started to unlock the men on HB 1. When the first officer reached B2-22 and opened the observation panel, he saw the man lying at the side of the bed with shoelaces around his neck. The first officer radioed for medical assistance by calling "Code Yellow" and shouted to the second officer for help. The second officer was on the opposite landing and he reached the cell in

seconds. The two officers then entered the cell and the first officer cut the ligature with his anti-ligature knife. As they placed the man on the floor, a senior officer arrived followed by a principal officer. The first officer and the second officer then left the cell.

45. The principal officer is a qualified first aider and has, in the past, been a first aid trainer. He felt for a pulse in the man's neck but could not find one. After noting the man's colour and that he was very cold, his opinion was that the man was already dead. He therefore instructed the staff not to begin cardio pulmonary resuscitation (CPR). One of the officers (it is not clear who) asked for an ambulance to be called.
46. A duty staff nurse was in the healthcare centre when she heard the Code Yellow call. She was Hotel 3, the duty nurse for responding to medical emergencies that day. She immediately collected the emergency equipment bag and defibrillator and went to HB1. (A defibrillator is a machine that treats victims of sudden cardiac arrest by delivering a shock to the heart.) As she moved through the prison, staff in HB1 called her on the radio several times to ask how long it would be until her arrival. Although she did not know what the emergency was, she realised from these calls that it was serious. When she reached HB1, staff had already unlocked the door so that she could go straight in.
47. When the nurse reached the man, her immediate opinion was that he had been dead for some considerable time. When she examined him, he was not breathing and his face had turned bluish. His pupils were fixed and dilated and he felt very cold. His left arm was locked in a raised position and his legs were slightly bent, indicating that rigor mortis had set in. The nurse therefore decided not to try to resuscitate the man. Annex C of Prison Service Order 2700 "Suicide and Self-Harm Prevention" instructs staff not to resuscitate a prisoner who has died as a result of hanging where rigor mortis has clearly set in. It is not respectful either to staff or to the person who has died to commence CPR in such circumstances.
48. The nurse radioed for the senior nurse on duty. When the senior nurse examined the man, she agreed with the staff nurse's decision not to start CPR. Then the paramedics arrived and confirmed the decision not to try to resuscitate the man, as did a prison doctor who also attended.
49. The care and welfare team contacted each member of staff who was involved in finding and attending to the man. They also visited the prisoners on the houseblock to check on their welfare. Staff also reviewed all prisoners who were on open ACCT plans. The deputy governor chaired a hot debrief later that morning, which most of the staff attended. The deputy governor told my investigator that, by mistake, two of the nurses were not told of the meeting. However, he had taken steps to ensure that, in future, all members of staff who were involved would be invited to the debrief.
50. Accompanied by a member of the chaplaincy team, one of the prison's family liaison officers (FLOs), went to break the news to the man's family. The prison's FLO and a senior officer arranged a further meeting with the family at which the

man's belongings were returned and funeral arrangements were discussed. The man's funeral was held on Friday 28 September. The family were invited to visit the prison but declined.

ISSUES

Health

51. A review of the man's clinical care and his report is at Annex 2 of this report. The clinical reviewer concludes:

"The medical and psychiatric care of the man at HMP Blakenhurst was entirely appropriate ... In my opinion, the single most significant risk factor for suicide would have been the man's extensive psychiatric history rather than his confinement in prison; but the catalyst was the imminent court date."

He has made no recommendations.

52. The man was treated for a number of minor physical problems for which the doctor referred him to physiotherapy and chiropody. This included treatment for in-growing toenails at a local hospital. He also consulted an optician and was waiting for new glasses when he died. However, the man's main contact with healthcare staff was for his mental health problems.
53. The nurse in reception assessed the man and identified what the clinical reviewer describes as "significant issues with mental health." As a result, the man was put under the care of the Forensic Liaison Nurse in the Forensic Liaison Team. For the duration of his time in Blakenhurst, the man had a minimum of fortnightly appointments with either the Forensic Liaison Nurse or one of the team psychiatrists. After he set fire to his cell, he was admitted to the in-patients unit in the healthcare centre where the psychiatrists assessed him on a weekly basis. The doctors prescribed anti-depressants and, at a later date, anti-psychotic medication.
54. The man did not always take his medications, most notably on the day he set fire to the television in his cell. He again refused his medications on 3/4 July when he also appeared unkempt and wrote on his cell wall, "The devil is here." Staff persuaded the man to resume his medication and two days later the psychiatrist added the anti-psychotic to the prescription.
55. Throughout his time in Blakenhurst, the man expressed thoughts of hopelessness and self-harm. Staff opened an ACCT plan and the man spent several weeks as an in-patient in healthcare. His release back to the houseblock was gradual to help him adjust more easily to the move. Once on the houseblock, he settled fairly well and interacted with other prisoners, particularly his friend. In the days before 14 September, he told several people that he was worried about the length of sentence he would be given. However, his behaviour did not give rise to particular concern.

ACCT procedures

56. After the man set fire to the television in his cell, the staff nurse opened an ACCT plan to provide additional support for him. PSO 2700 "Suicide Prevention and Self-Harm Management" sets out the procedures that staff must follow for

opening, maintaining and closing an ACCT plan. Staff opened the plan in the early hours of 12 July and completed the immediate requirements during the day. However, I have a number of concerns about how the procedures were subsequently conducted.

57. Once staff had assessed the man as being fit to return to HB6, he was transferred to the segregation unit under Prison Rule 53(4). This states that a prisoner who is awaiting an adjudication hearing may be kept apart from other prisoners (almost always in practice by being relocated in the segregation unit) until the hearing takes place. The man was moved on 12 June and the hearing took place three days later. PSO 1700 "Segregation" states that separating a prisoner under Rule 53(4):

"... must not be an automatic measure but be used where there is a real need, such as the risk of collusion or intimidation relating to the alleged offence, which segregation of the accused might prevent."

58. The man had been accused of setting a fire to his cell and it therefore could well be argued that he posed a risk both to staff and other prisoners. However, PSO 2700 "Suicide Prevention and Self-Harm Management" states:

"Prisoners on an open ACCT Plan or in the post-closure phase of ACCT (i.e. the ACCT Plan has been closed, but the final post-closure review has not been signed off) must not be located in accommodation (such as a segregation unit or special accommodation) that reduces their access to social support, other people, activities and stimulation unless, exceptionally, they are such a risk to others that no other suitable location is appropriate and where all other options have been tried or are considered inappropriate."

59. The man had been prescribed anti-depressants four days earlier, had been admitted to healthcare as an in-patient earlier that same day, and was on a very recently-opened ACCT plan. Given these factors, I question whether the risk the man posed was such that the segregation unit was the only suitable location for him. On 12 July, healthcare staff assessed the man as being fit for normal location, but after three days in the segregation unit the psychiatrist re-admitted the man to the in-patients unit for a week's observation

The Governor should remind staff to fully consider the requirements of PSOs 1700 and 2700 before segregating a prisoner on an ACCT plan under Rule 53(4).

60. The ACCT plan was closed on 1 July, the day before the man appeared in court and was convicted. The notes of the case review meeting, at which staff and the man decided that he was coping well enough not to need the additional support, makes no mention of the court date. After the man was convicted, he told a number of people that he was worried about the length of sentence he would receive. He said to the Forensic Liaison Nurse, "If I could get to know ... what I was serving, I'd know where I was heading." The man expressed these anxieties only after his conviction. However, I consider it prudent for case reviews of remand prisoners to consider impending court dates before closing an ACCT.

61. Once an ACCT plan is closed, there must be at least one post-closure review to check how the prisoner is coping. When the man's ACCT plan was closed, the date for the post-closure review was not set. A note merely said, "TBA" (to be arranged).

The Governor should ensure that all prisoners on ACCT plans have at least one post closure interview as required by PSO 2700.

OSG night duties

62. The officer discovered the man at 7.30am whilst he was unlocking the prisoners. By that time, the man had been dead sufficiently long for rigor mortis to have set in. It is not possible to say when the man took the action that led to his death. If the OSG on duty in HB1 that night, had carried out a morning roll check she would have seen the man at around 6.00 am. However, it is not possible to say whether the man would still have been alive at that point.

63. I am concerned that the OSG's understanding of her role and responsibilities on night duty differed markedly from senior managers' expectations. The OSG told my investigator very firmly that she did not have to check the prisoners visually. She went round the houseblock cell by cell only to check for herself that each door was securely locked.

64. The OSG's understanding of her duties is a disappointing echo of my findings concerning the death of a prisoner at Blakenhurst in 2006. In my report into the earlier death I said:

"The initial 'check' by the oncoming night member of staff is most usually a count of every prisoner on the unit and a check that they are all okay. It is not a 'cell door check', not a 'lock check' but a physical count and check of all the prisoners on the wing."

65. I must repeat here my earlier recommendation, with particular emphasis on the necessity of training (re-training where required) all staff who perform night duties.

The Governor must ensure that night staff are reminded of their correct role and responsibilities at night and that they receive training and written guidance where necessary.

66. The OSG and the officer accompanying her at interview were also adamant that a roll check at 6.00 am was not required. When asked about the space on the night duty form for a morning roll check total, the OSG said that she entered the 8.45pm total from the previous night. They said that after the 8.45 pm roll check, the next required roll count was just before lunch the following day.

67. After interviewing the OSG, my investigator raised the issue of a 6.00am roll check with the operations manager. He identified as a training issue the need to educate all staff that a 6.00am check must always be carried out. Later the same

day, he issued an instruction to all staff, listing all roll check times to be completed each day.

The Governor should ensure that management checks cover roll checks and the manner in which are conducted.

The ligature

68. The man used his shoelaces as a ligature and his family have questioned why staff had not taken the laces from him. However, prison staff have a duty of care to those they look after, as well as a responsibility to treat them with dignity. In deciding which items someone can have in their possession, staff walk a fine line between keeping a prisoner safe and preserving his dignity. The man was not on an ACCT plan at the time and staff saw no signs that he was in danger of harming himself. Therefore, they did not remove his laces or any other items that could have been used as a ligature. Notwithstanding the tragic outcome, I do not believe that staff were mistaken in their judgements given what they knew at the time.

Conclusion

69. The man spent five months at Blakenhurst, for five weeks of which he was an in-patient in the healthcare centre. Throughout his time in prison, he had regular appointments with the nurse and psychiatrists in the forensic liaison team. However, he was not convinced that anti-depressants helped him and did not always take the medication he was prescribed.

70. As the date for his return to court for sentencing approached, he appeared very anxious. He told a number of people that he would only be able to settle once he knew how long he had to serve. Sadly, he died three days before returning to court.

71. In the clinical reviewer's opinion, the man's long history of mental health problems was a significant risk factor. However, the catalyst was the imminent court date.

72. Although I have concerns about night procedures and the absence of a post-closure ACCT review, I do not judge that Blakenhurst could reasonably have anticipated that the man would take the actions he did. Sadly, there are many prisoners like the man who have a history of mental instability, and many are anxious about their trial, the sentence they may face, and their ability to cope in prison.

RECOMMENDATIONS

1. The Governor should remind staff to fully consider the requirements of PSOs 1700 and 2700 before segregating a prisoner on an ACCT plan under Rule 53(4).

The Prison Service response was:

“Only Governor grades can authorise placing a prisoner in the segregation Unit. The requirements of PSO 1700, PSO 2700 are outlined in Suicide Self Harm Prevention Policy and Procedure.
The particular paragraph will be emailed to all governor grades.”

2. The Governor should ensure that all prisoners on ACCT plans have at least one post closure interview as required by PSO 2700.

The Prison Service response was:

“All post closures are complied by AO in safer custody. Every open ACCT has one completed. The on going log monitors to ensure all closed ACCT are reviewed.”

3. The Governor must ensure that night staff are reminded of the correct role and responsibilities at night and that they receive training and written guidance where necessary.

The Prison Service response was:

“A check list is already in place giving guidance and instructions on what needs to be undertaken during the roll check.
Instructions will be issued to the Night Orderly Officer to ensure that staff are aware of these instructions and the correct procedures to be followed.”

4. The Governor should ensure that management checks cover roll checks and the manner in which are conducted.

The Prison Service response was:

“Instructions will be issued to the Night Orderly Officer to ensure that staff are aware of these instructions and the correct procedures to be followed.”