

**Investigation into the death of a man
at a hospital, on
10 September 2004, while a prisoner at
HMP Blakenhurst**

**REPORT BY THE PRISONS AND PROBATION
OMBUDSMAN FOR ENGLAND AND WALES**

OCTOBER 2006

This is the report of an investigation into the death of the man who died in hospital, on 10 September 2004, while a prisoner at HMP Blakenhurst. the man was 48 years old when he died from pulmonary embolus and deep vein thrombosis.

My colleagues and I extend our sincere condolences to this man's family and friends in their sad loss.

This investigation was completed by one of my colleagues. I am grateful for the assistance that my colleague received from the Governor of Blakenhurst, and his staff including the residence governor, who acted as the establishment's Liaison Officer. I regret the delay in the issuing of this report. This was caused in part by a delay of over 12 months before I received the clinical review commissioned by the relevant Primary Care Trust.

A key objective of all my investigations is to make sure that the bereaved family has the opportunity to raise any concerns and contribute to my inquiries. In this case, the investigation team was able to meet with the man's cousin. I am most grateful to him for agreeing to this meeting at what must have been a very difficult and distressing time.

No-one should under-estimate the difficulties of caring in a custodial environment for a patient like the man who came into prison with a complex range of medical and psychological problems. This report documents how HMP Blakenhurst rose to those challenges. However, as with so many prisoners, the fundamental problem was that prison was not really a suitable location for him at all.

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PRISONS AND PROBATION OMBUDSMAN**

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Summary

1. The man was born in July 1956 and was 48 years old when he died at Alexandra Hospital, Redditch, from pulmonary embolus and deep vein thrombosis on 10 September 2004.
2. He had arrived at HMP Blakenhurst on 17 May 2004, following an assault on police officers and threats to kill his mother. Staff were made aware that he had an established history of epilepsy and mental health problems. This had meant that he had frequently been admitted to psychiatric hospitals and was difficult to manage in a community setting, where he had most recently lived with his mother. There were over 100 episodes recorded when the man had violent outbursts against those involved in his care.
3. Attempts were made by staff at Blakenhurst to manage the man appropriately. There was continuity between his community psychiatric team and both the In-Reach and Forensic Medical teams. For the first month, he was successfully managed on the lower medical wing as an inpatient, but he was then moved to the segregation unit following episodes of violent and abusive behaviour.
4. It was acknowledged early on by various people involved in the man's care that the segregation unit was not the most appropriate place to manage him. It was also noted in his records that his mental health generally deteriorated when he was located there. However, neither the normal location house blocks nor the lower medical inpatient wing were considered appropriate locations due to his aggressive behaviour. As his mental health continued to deteriorate, he had more frequent assessments by his psychiatric teams. Attempts were made to obtain a suitable placement for the man outside Blakenhurst, preferably in a secure psychiatric hospital. It was difficult to find appropriate accommodation for him due to his history of aggression and verbal threats to staff. There is documented evidence that he tried to strangle a member of the care team, and that he had to be restrained on two occasions by officers when he became violent.
5. F2052SH self harm warning forms were opened for this man twice, as he had expressed thoughts of suicide, a desire not to be in prison and regrets about his mother.
6. The man also sometimes refused to take his medication. Initially, he refused any medication that was not to control his epilepsy, but by the end of August 2004 he was also refusing that medication. His medical record shows that staff persistently tried to encourage him to take his medication but he still refused. This led to an increase in seizures and a deterioration in his physical health which resulted in him being admitted to a nearby hospital, on 3 September, following repeated and prolonged seizures that day.
7. At the hospital, the man was identified as having an infection on the right side of his chest and associated heart arrhythmias (irregular heart rhythm), probably as a result of toxic build up through the infection. During his time in the hospital he was not always co-operative with the treatment provided, and he pulled out the device to give him intravenous drugs and fluids. He also refused to take sufficient water and food.

Staff found him difficult to manage and also tried to find a suitable location for him, but were not successful. The man was also seen by his community psychiatric team. I understand that a secure psychiatric hospital in Manchester was identified as a possible location for him. Sadly, he died on 10 September before this was investigated further and arrangements could be made to transfer him. The cause of death was noted as pulmonary embolus and deep vein thrombosis.

8. The clinical review carried out concludes that all attempts were made by staff in Blakenhurst to manage the man in an appropriate way. The review notes there was continuity of care between the community psychiatric team and the in-reach and forensic mental health teams.
9. One of my Family Liaison Officers contacted the man's cousin. He expressed concerns about the role of the various psychiatric teams involved in his cousin's care before he was located in Blakenhurst. He also complained about the role of the hospital from when his cousin was admitted on 3 September until his death on 10 September. Both these issues are outside my remit.
10. The man's cousin also raised specific concerns about the care and treatment of his cousin by Blakenhurst which are addressed in this report.
11. This report makes three recommendations.

Background

The man

12. The man was born in 1956. He was diagnosed with temporal lobe epilepsy at the age of 11 years. He attended mainstream education. However, it is reported that due to his father's career, the family lived in many different places throughout his childhood and his schooling was disrupted. As a teenager he apparently showed promise in both academic subjects and sport. He had a long-standing history of epilepsy and mental health problems. At the age of 21, the man's mental health deteriorated and he was eventually diagnosed with paranoid schizophrenia. In 1979, he moved to live and work at a specialist centre for Epilepsy in Buckinghamshire, returning home to his mother at the weekend. He lived there for ten years and then returned to live permanently with his mother. His employment at the Centre had ended when he attempted to attack a colleague with a knife whom he believed was the son of the devil. There were also reports that he had hit his manager. After that he was frequently admitted to hospital and at times he was detained under the Mental Health Act.
13. On 9 August 2001, the man was admitted to hospital. On 31 August 2001, he was detained under the Mental Health Act. In December 2001, he had a vagal nerve simulator fitted as a method of controlling his epilepsy. On 18 October 2002, he had a Care Programme Approach (CPA) assessment. It was noted that he had aggressive and violent outbursts, against both his mother who was his main carer, nursing staff and other patients. This had led to the police being called several times.
14. The man remained an inpatient at the hospital until he was allowed home leave from 21 to 23 January 2004. He was allowed home permanently shortly after this but remained as a day release patient at another hospital.
15. He was again admitted to the same hospital from 13 to 20 April 2004 and 22-23 April for assessment as he appeared confused and muddled. A consultant psychiatrist, Doctor F, noted that he settled and became more orientated. She saw him again on 19 April, when he had become aggressive and threatening towards staff. Police were called and restrained him. He was not charged with any offence and later apologised for his behaviour. A discharge planning meeting was held on 19 April and the man was discharged back to stay with his mother. He returned to the hospital on 22 April due to being agitated, talking about coincidences and whether he was the Son of God. On 23 April, Doctor F discussed a management plan for him with a consultant forensic psychiatrist, and several other members of staff including the Medical Director. They concluded that the man did not have a chronic psychosis. He returned to live with his mother and was monitored in the community from 23 April, with reviews in the day hospital and assistance from a Community Psychiatric Nurse CPN. His mother was advised that she should report any incidents of aggression or violence towards her to the police.
16. On 14 May, the man threatened to kill his mother. On 17 May, there was an incident at his home address in which his mother received a head injury from which she later died. The man was taken into police custody on suspicion of murder and for

assaulting police officers. However, before she died later the same day, the man's mother denied that he had assaulted her and said she had fallen. Consequently, taking into account the man's mental health problems, the Crown Prosecution Service (CPS) concluded that there was insufficient evidence to support a charge of murder and he was therefore charged with threats to kill. The man was remanded into custody at Blakenhurst on 17 May from Leamington Magistrates' Court.

17. Pre-convictions for the man indicate that he had one previous charge of criminal damage caused between 12 and 18 November 2003 and a charge of threats to kill at the same time, which seems to have been subsequently dropped. Prison records show that he was remanded at HMP Leicester for one day.
18. The man's cousin confirmed to my investigation team that his cousin had a long history of mental illness and severe epilepsy. He said that he had attacked his own mother on several occasions, and had also attacked his (the man's cousin) mother in the past.
19. The man's cousin expressed concern generally about the man's treatment for his psychiatric problems before and during his imprisonment. He mentioned specifically an occasion, before his cousin was located in Blakenhurst, when he had been sectioned under the Mental Health Act and had been sent to a hospital in Leicester. He was concerned that his cousin's diagnosis was suddenly changed from schizophrenia to anger management problems at that time and he was discharged from the hospital. The man's cousin said that the man was discharged with no help to get anywhere, and returned home to his mother's house where he lived for a further four or five months. He said that his cousin's mental health deteriorated significantly from May 2004 and he began saying that he was the Son of God.
20. The man's cousin said that, before the man was arrested on 17 May, he entered a chemist's shop and told the pharmacist that he needed help and needed to be sectioned under the Mental Health Act or he was going to harm his mother. They called the police who apparently said they could not arrest him as he had not broken any law. This prompted him to assault a police officer to get himself arrested, which is what happened. While in police custody he apparently told staff that if they released him he would kill his mother. According to the man's cousin, the mental health team said the man could be discharged and he was released. He then attacked his mother and it was after this attack that she died and he was arrested and imprisoned. The man's cousin said that the man's mother was scared of her son.
21. The man's cousin said that he visited the man on several occasions in Blakenhurst and noticed a marked deterioration in his condition with each visit. He said he challenged the staff about the clothes his cousin was wearing, which he felt were too big for him and humiliating to wear as he was not eating and had lost a lot of weight. The man's cousin said that he asked prison healthcare staff, the man's solicitor, and the Community Psychiatric team on several occasions to get him moved from Blakenhurst to a psychiatric hospital for treatment. He said that nobody listened to him or did anything in this respect. He is aware that the man refused to take his medication and said that he felt he had lost the will to live after what he had done to

his mother. In his opinion, the assistance offered to his cousin by a nurse was insufficient to deal with his problems.

22. The man's cousin said that when he saw the man in hospital, he was appalled by what he saw. He alleged that his cousin was beyond recognition, chained to the bed in a nappy and looked like he was being treated like an animal. Three prison officers were present at all times. He said that this sight upset him and his wife and he could not believe a human being was treated like this. The man's cousin said that, after three days, the man came around a bit and recognised him. He said that the man was not eating or drinking, but hospital staff told him they could not put a drip on him because he refused the treatment. As he had not been sectioned under the Mental Health Act, they could not impose treatment.
23. The man's cousin said that he was informed about the man's death by the police and had not been contacted at all by Blakenhurst. He alleged he had had no possessions back, no letter of condolence, nor an offer of funeral costs.

HMP Blakenhurst

24. HMP Blakenhurst is located on the outskirts of Redditch in Worcestershire. It is a local prison, serving a number of courts in the West Midlands. In September 2004, Blakenhurst had an operational capacity of 856 adult males held principally within four identical houseblocks. (Most prisoners are held in double cells with separate specialist units including the healthcare centre and a segregation unit. Roughly a third of the population are unsentenced remand prisoners.)
25. In September 2004, healthcare was provided by a Healthcare Manager, two G grade nurses, two F grade nurses, 14 E grade nurses, five A grade nurses, two clerical staff and one E grade nurse on nights. There was a total of three full time and one part time Registered Mental Health nurses, RMN's, supported by agency staff when required. There were 29 inpatient beds and one gated cell. Some specialist mental health input was provided by a psychiatric consultant from a Psychiatric Clinic, Birmingham, and also from a forensic psychologist. Blakenhurst now has a forensic team comprising of a consultant with two specialist registrars, plus the forensic psychologist. They also have a much larger team of RMN's providing cover for their 24 hour healthcare centre and for out-patient clinics. The mental health in-reach team also attend the prison. They only have 21 beds now.
26. Her Majesty's Chief Inspector of Prisons (HMCIP) carried out an unannounced inspection of Blakenhurst in April 2002. The inspection report described Blakenhurst as 'a dynamic prison which was working towards becoming a healthy prison'.

Conduct of the investigation

27. My investigator studied all relevant prison records relating to the man. These included his main prison record and his Medical Record.
28. A Public Health Consultant from Redditch and Bromsgrove Primary Care Trust (PCT) carried out a clinical review.
29. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. A copy of the post mortem report dated 20 September 2004 was received and recorded the cause of death as pulmonary embolus and deep vein thrombosis.
30. One of my Family Liaison Officers contacted the man's family. His cousin raised concerns about the man's treatment for his mental health problems and epilepsy both prior to his arrest and whilst in custody.
31. My investigator visited Blakenhurst and discussed aspects of the man's treatment with a range of staff at the prison. These included the Deputy Governor and the Head of Healthcare. My investigator also met the Chair of the local branch of the Prison Officers' Association (POA), and representatives of the Independent Monitoring Board (IMB), to tell them about the investigation process.
32. The clinical review found that 'all attempts were made to manage the man in an appropriate way. There was continuity between his community psychiatric team and both in-reach and forensic mental health teams.'

The man's time at Blakenhurst

33. The man was remanded into custody at Blakenhurst on 17 May 2004 and was immediately located in the lower medical ward in the healthcare centre.
34. On 19 May, a Medical Disruptive Prisoner risk assessment and management plan was completed by a registered mental health nurse (RMN). He noted that further information was obtained from the man's Community Psychiatric Nurse (CPN) and psychiatrist, which stated that he had a history of violence with over 100 unprovoked and unpredictable incidents recorded. A three officer unlock was implemented as a result of the assessment. (That is, the man could not be unlocked without three members of staff present.) This was later reduced to a two officer unlock on 25 August.
35. A self-harm warning form, F2052SH, was opened by a nurse on 27 May after concerns were expressed by a senior probation officer, following a MAPPA meeting (Multi-Agency Public Protection Arrangements). Their concerns were that the man might self-harm when he realised that his mother had died. The care plan for the man was Level 3 Observations, access to nursing staff, weekly visits by the CPN, and bereavement counselling. (Level 3 observations are hourly observations at irregular intervals.) There is no evidence that the man saw a counsellor specifically to deal with his bereavement.
36. On 30 May, there is a note that the man was to remain in the healthcare centre, but there was a risk of him becoming violent. The F2052SH was closed on 6 June following a review by a governor and a nurse. It was closed as the man had not made any attempts at self-harm during that time and there were no concerns from nursing staff. There was no support plan put in place when the F2052SH was closed.
37. On 13 June, there is a note that the man was at times abusive and threatening towards staff. The man was still located in the healthcare centre during this time and generally complied with medication and food and drink intake. However, on 16 June his behaviour started to deteriorate and he was re-located to the Segregation Unit on 19 June. This was following several episodes of being verbally abusive to staff, flooding his cell, throwing his food and barricading his cell door.
38. On 24 June, the man was seen by a Community Forensic Psychiatric Nurse (CFPN), and Doctor A, a Senior House Officer. They said that he was much more articulate, and was co-operative, but did become verbally intimidating at times. He was not physically aggressive and was fully aware of why he was in the segregation unit. There is a note that he talked throughout the night on 27 June about God and Jesus Christ. The man was seen again by the CFPN on 1 July. He said that the man was not psychotic and his behaviour was seen to be reasonably well controlled. He said that the man had felt suicidal, and had tried to pierce his throat with a plastic knife, but no marks were noted on his neck.
39. The man fell out of his bed on 3 July and suffered a minor cut over his right eye and a raised lump with bruising over his left eye. It was noted that his behaviour was bizarre and he said he was the Holy Spirit.

40. There is evidence that the man's behaviour continued to deteriorate during June and early July. On 8 July, he was very agitated and said that he would put in a charge of attempted murder against staff. He had to be restrained by two officers when he attempted to get out of his cell during a doctor's rounds. There were no injuries noted to the man and he was pushed back into his cell. Doctor B, a Senior Prison Medical Officer, said that in his opinion up until the beginning of July the man had been reasonably settled and appeared not to be having seizures. He was on five different anticonvulsants to control his epilepsy. Doctor B noted that the man's behaviour had recently changed distinctly and he appeared to have had at least one seizure, suffering abrasions on his forehead as a result. He also noted that the man had begun to neglect himself and his cell. He said that previously he had not considered there were any mental health problems to address with the man, but now felt that the segregation unit had adversely affected him mentally and that he needed to be reassessed. Doctor B referred the man for a further mental health assessment and he saw Doctor C, a Consultant Psychiatrist for Worcestershire Mental Health Trust, on 16 July.
41. The man remained in the segregation unit and a segregation review was held on 12 July. The review concluded that, although the segregation unit was not an ideal location for the man, he would need to stay there due to his unpredictable and violent behaviour. The Deputy Governor asked that the matter be raised with the Psychiatric Team regarding the possibility of a hospital placement.
42. The MARC (Multi-Agency Risk Conference), which had been held on 11 June, recommended that a F2052SH should be opened and remain open irrespective of the man's mood and behaviour. This had not happened and the F2052SH was reopened on 15 July by a nurse. The reason given for reopening the F2052SH was that the MARC had identified the man as at risk of self-harm once he realised that he was likely to be charged with the death of his mother. The advice of the MARC was that the F2052SH was to remain open for the foreseeable future. The nurse did not feel it appropriate to explain to the man the whole reason for opening the F2052SH. It was noted that he had not given any indication to segregation staff that he intended to self-harm. The support plan was to continue with Level 3 observations and to have healthcare input into F2052SH reviews and segregation reviews, which did happen.
43. On 16 July, Doctor C undertook a psychiatric reassessment as requested by Doctor B. He recommended that the man should be moved back to the healthcare centre as an inpatient. He felt that being in the segregation unit may have led to a deterioration in the man's mental health. He concluded, 'I will ask Doctor D to see him due to the risks involved. It may be that he should be moved back to Lower Medical on a 2 or 3 man unlock to help stabilise him.' (Doctor D is a Consultant at the Psychiatric Clinic, Birmingham).
44. The man had a self harm case review on 19 July, by a nurse and Doctor B. It was noted by Doctor B that the man had not given any indication that he intended to self-harm. He noted that the man could be returned to normal location. This did not happen and the man remained in the segregation unit, although he did return briefly to the healthcare centre on 11 August. On 19 July, the Healthcare Manager noted

that she had taken part in a specific case review to determine the man's future location. She wrote, 'Viewing the IMR there seems to be no clinical indication for admitting him to healthcare, but segregation staff are concerned about his mental health deteriorating if he remains in their unit. I have suggested that he could be managed in a structured regime on the houseblock but this is currently unavailable. I will discuss with other healthcare staff a way to take this forward and it may be allowing him to associate in lower medical and being housed in segregation for the time being.'

45. On 20 July, a further MARC meeting was held to discuss the man. It was noted that during the review the man appeared calm but asked why he was in prison. The Deputy Governor explained that his mother had died and he replied, apparently in a detached and matter of fact way, 'I'm sorry if I killed my mother.' There were no current issues about refusing food or drink.
46. Another F2052SH review was held on 21 July. The support plan was to maintain Level 3 observations, review appropriate location, and maintain interaction. On 21 July, the CFPN and a social worker discussed the man's management plan. Their opinion was that the segregation unit was not the most suitable location for the man and that his behaviour was unpredictable. They noted that he had previously been managed in a more open environment, either in a hospital or in the community. They felt that he did respond to firm, but calm management, and that being in the Segregation Unit for a prolonged period might increase his hostile behaviour. Initially, the man might be challenging to manage if allowed out of the segregation unit, but they felt that could be achieved and that he would eventually settle.
47. On 23 July, Doctor D saw the man. He concluded that the man did not need to be in the Segregation Unit and could be managed on normal location where staff would be aware that he could be confused briefly after a seizure. There was no evidence to indicate that the man had suffered any seizures during the previous three weeks that Doctor D had been observing him.
48. On 26 July, another F2052SH review was held for the man. The man said he did not have any intention of self-harm and did not recall shouting or being violent towards staff. It is recorded that he admitted killing his mother during the review, but said he did not recall what happened. The review panel were concerned that the F2052SH was being kept open just because of the decision of the MARC panel. The man's support plan was for Level 3 observations to continue, for him to comply with medication and to have continued support from the CFPN. There was also a segregation review the same day. This was documented by a nurse who noted that the man became annoyed when his previous volatile behaviour was mentioned. He apparently maintained that he had never been violent and then said that his epilepsy had been 'visited upon by those who were sons of the devil' and that he was under the influence of the devil when he killed his mother.
49. During another F2052SH case review on 28 July, the man said he had no thoughts of self-harm and a governor explained to him that the F2052SH was open as there were concerns that he might harm himself if he remembered what had happened to his mother. The F2052SH was to remain open until contact was made with the Multi-Agency Public Protection (MAPP) team. The support plan was for Level 3

observations to continue and for him to be encouraged to take his medication. A F2052SH review held on 4 August noted that he looked as healthy as he had ever been. The support plan was for him to remain on Level 3 observations, take his medication and for staff to continue to interact with him. The 29 July segregation review notes that the man behaved 'largely normally and appropriately' and 'had no mental health needs to address although it is difficult to see him settling amongst the general prison population.' He requested occasional sedation which the doctor did not feel was unreasonable while he was in the segregation unit.

50. There are letters dated 3 and 4 August from Doctor D to Doctor B, and the Consultant Forensic Psychiatrist respectively. Doctor D had been reviewing the man for several weeks. The letter to Doctor B recommended that the man should be admitted to the healthcare centre for an assessment over two weeks, as it was considered that there had been deterioration in his mental state over the preceding week. He said that he would liaise with the Consultant Forensic Psychiatrist. Between them they would look at devising a comprehensive management plan over the two weeks to give them a better indication of where the man would be best located within the prison.
51. On 7 August, the man was seen by a RMN, who noted that his right elbow was swollen and felt soft and palpable and a little hot to touch, possibly because of an infection. There was no known cause and the man was not complaining of any pain. A bruise was also noted to the inside of his upper left arm. He was referred to see a doctor. He was seen by a doctor on 9 August, signature illegible, who noted, 'has some bruising on his right upper arm and tingling of his right 5th finger. Seg staff report a change in his manner and speech over the last few days. Not sure if he has had a fit but this is the most likely explanation for a right elbow injury'. The support plan was to continue to observe him. It is not clear whether the man's elbow was examined further or treated.
52. A segregation review was also undertaken on 9 August. A note prepared by the RMN said that staff suspected that the man might have had a seizure over the previous three days, but this was not witnessed by anybody. There was discussion about re-locating him to the healthcare centre for a period of assessment as recommended by Doctor D. From a nursing perspective, it was felt that this was not appropriate and would not be of any therapeutic value to him. It was noted that Doctor D was to refer the man back to the Consultant Forensic Psychiatrist to establish a care plan. There was reluctance within healthcare to receive the man back to the healthcare centre because he was difficult to manage and had violent outbursts. However, he was moved there on 11 August after he returned to Blakenhurst from an outside hospital visit to Doctor E, a Consultant Neuropsychiatrist, regarding his epilepsy.
53. During the evening of 11 August, the man began to destroy his cell. Two officers entered his cell to try to calm him down. The man is reported to have punched one of the officers in the face. Control and restraint (C&R) immediately took place during which the man is reported to have headbutted the officer and he was returned to the segregation unit. The man sustained minor injuries during the initial restraint and relocation from the healthcare centre to the segregation unit, a cut to his top lip and redness over his back area and wrists. His left leg was grazed and red below the

knee cap. He was seen by a nurse and did not require any medical treatment. His behaviour continued to fluctuate and he remained agitated.

54. A prisoner at Blakenhurst at the same time as the man expressed concerns to my investigator about the man's treatment during this restraint and generally by a specific officer. A report of the man's restraint was produced at the time and detailed the circumstances and minor injuries he sustained. The Officer in question no longer works for the prison service so it would not be practical for the Governor to pursue this further by way of investigation, although he may wish to review the management of restraint procedures overall.
55. On 12 August, the man had a visit from the CFPN and the CPN. He was described as co-operative, but said he was frustrated with the prison system. He said that he wanted to kill himself and was sorry for killing his mother. They noted that he had various injuries to his body: his right arm was swollen, his elbow was bruised and his left large toe was swollen. On 13 August, Doctor D reviewed him in the segregation unit with another doctor. He noted that the man had some bruising to his body, which he said he sustained while he was being restrained. He said that he did not have any thoughts of self-harm. The care plan was for the man to remain in the segregation unit if feasible and to be reviewed by a doctor on a regular basis.
56. On 16 August, the man had a segregation review which was recorded. This said that the man was calm, talkative and rational and went to chapel that day. The plan was to continue to slowly integrate him into normal location.
57. On 21 August, Doctor D saw the man in the segregation unit. He noted that the man was becoming increasingly preoccupied with numbers, behaviour which was bordering on psychotic. He said that he had been told by the Consultant Forensic Psychiatrist that a contact of Doctor F's was trying to locate a bed for the man in a secure psychiatric hospital. Doctor D noted that he would write to Doctor F about the matter.
58. On 22 August, the man was again seen by a RMN for a segregation review. It was noted that he was agitated and aggressive and was naked in his cell. He refused his morning medication. It was also noted that, if he continued to refuse his medication, he was to be referred to the doctor. The note in his medical record says, 'Again refused medication at midday, despite great effort to explain its necessity. Behaviour becoming increasingly bizarre and hostile. Talking about being God and says that the prison staff are disciples to the devil.' The care plan was to encourage the man to take his medication and, if he continued to refuse, to refer him to the doctor. His possible admission to the healthcare centre was to be kept under review. He was also to have had a F2052SH review on 22 August, but it was noted, 'unable to convene a review with the man because of his present condition, pacing the cell naked and talking in a bizarre fashion. He has grabbed at staff, possibly in an attempt to leave the cell. Having read his file there is apparently information which we are unaware of which may require further case reviews and so we decided to keep the form open.' The support plan was to continue with Level 3 observations, and to arrange a meeting to draw up a management plan as soon as possible.

59. On 23 August the man was seen by a doctor (no signature) in the segregation unit. He had been swallowing paper in what was seen as a suicide attempt. He appeared very disturbed, possibly psychotic and there were concerns about the 'poor' treatment for his epilepsy. It was recommended by the doctor that Doctor D should pursue a bed in a psychiatric hospital for the man. In the meantime, the man should be transferred back to the healthcare centre. The man had started to refuse any medication that was not to control his fitting. By the end of August, he started to refuse to take all his medication including his medication for epilepsy. Records note that staff persistently tried to encourage him to take his medication. It appears that he was transferred to the healthcare centre on 24 August, but this is unclear from the records.
60. On 25 August, another Medical Disruptive Prisoner Risk Assessment was undertaken. A management plan was implemented for the man which was for him to have a two officer unlock, with a member of healthcare staff present, to exercise on his own in the exercise yard, and to have a regular mental health review. A record of all his behaviour was to be maintained.
61. By 27 August, there are notes in the man's medical record that he had become more psychotic, which was possibly linked to his temporal lobe seizures due to his refusal to take his medication. He was seen by Doctor D and Doctor F. Doctor D noted that the man was clearly psychotic and was probably having temporal lobe seizures. He noted that the man told him he was the 'Son of God', that he was 'special' and thought that a picture was talking to him. According to the notes, the man did not remember what had happened over the previous three months and did not remember that his mother had died.
62. Throughout August, records indicate that the man was seen frequently by psychiatrists, the forensic team, and community and in-reach psychiatric nurses. He became increasingly preoccupied with a combination of numbers and coincidences. He also indicated that he had thoughts of suicide, did not want to be in prison and regretted 'killing his mother'.
63. Attempts were made to try to locate suitable accommodation for him both within a nearby town and further afield. There is a letter from Doctor F, dated 3 September, to the consultant forensic psychiatrist, which details what recent consideration had been given to the most appropriate location for the man. The letter states that Doctor F and the Consultant Forensic Psychiatrist had spoken about the man on 9 August, 17 August and 2 September. During the telephone call on 9 August, after the Consultant Forensic Psychiatrist had visited the man at Blakenhurst, they had discussed whether there were any residential units for epilepsy sufferers which would be able to cope with the man's episodes of aggressive behaviour. Doctor F notes in the letter that she subsequently spoke to a Consultant Neuropsychiatrist from Stoke, who did not know of any such unit and said that managers were wary of accepting patients who might assault staff. Doctor F states in the letter that she also spoke to Doctor E, who was reviewing the man regarding his epilepsy, and who had recently been working at a residential unit for patients with epilepsy. He did not think that unit would be able to manage the man, but said he would make further enquiries and let Doctor F know.

64. Doctor F notes that she spoke to the Consultant Forensic Psychiatrist on 17 August, after a meeting when the CFPN had suggested that Doctor F refer the man to a medium secure mental health hospital. Doctor F notes that she then contacted Doctor G, a consultant rehabilitation psychiatrist in Leicestershire. Both she and Doctor G felt that they could not consider detaining the man long term, under section 3 of the Mental Health Act, as they considered his mental health was relatively stable when his fits were controlled. They concluded that he would benefit most from independent living, with a support package to help him establish himself.
65. Doctor F writes that the CPN had visited the man on 25 August and found him confused and disorientated, as he had not been taking his anticonvulsants regularly. Doctor F records in her letter that she spoke to the Consultant Forensic Psychiatrist on 2 September, after she had visited the man with Doctor D on 27 August, and they found his speech rambling with little recall of recent events. In view of this, Doctor F concluded that it was appropriate to transfer the man to a low secure private hospital under section 48 of the Mental Health Act, and a forensic case manager was to look for a suitable placement. Doctor F noted that, once the man's mental health was stabilised, his long term placement would need to be reconsidered. Meanwhile, it appears that the man remained in the healthcare centre at Blakenhurst, although this is not certain from the records.
66. During August, it was also noted that the man had started having more frequent epileptic fits which were more severe. On 1 September, the man refused to take his medication and he was found lying under his bed. On 2 September, he was found having been incontinent of urine, although nobody saw him having an epileptic fit. He had slept most of the night under his bed. He was later seen by the CFPN and another CPN, but was not sure whether he had had a seizure during the night. He complained of a painful left leg, which was warm and a little swollen, and he was unable to stand. He said that he was well cared for in the healthcare centre and was stupid not to take his medication. He saw a doctor that afternoon (signature illegible) who noted that his left leg had felt hot and painful when he woke up, but was 'a lot easier now'. The doctor was concerned that the man might have suffered a fit the previous night. There was no further mention of the problems with his left leg.
67. On 3 September, the man suffered a series of 'grand mal' seizures, repeated seizures which were difficult to control and long lasting, and was admitted by ambulance to hospital. At the hospital, signs of infection were identified on the right side of his chest and his white cell counts were raised, also indicating an infection. The diagnosis was thought to be status epilepticus (prolonged or repeated epileptic seizures, without recovery of consciousness between attacks) with a lower respiratory tract infection. Both these conditions were complicated as the man was found to have an abnormal heart beat. He was treated with intravenous antibiotics for the infection, antiarrhythmic therapy for the abnormal heart beat, and anticonvulsives to control the seizures.
68. The man's ongoing management was complicated by his agitated and erratic behaviour. It was difficult for staff to examine him properly and obtain a clear medical history. He repeatedly pulled out his intravenous antibiotics and sometimes refused to take his oral medication. He also refused to take adequate fluid and nutrition. Following a risk assessment by the prison authorities in which all the

necessary information was considered, the man was handcuffed to an officer and accompanied by two other officers at all times. The post mortem states that the cause of death was due to natural causes as a consequence of pulmonary embolus and deep vein thrombosis.

Clinical Review

69. The Clinical Reviewer concluded that all attempts were made by staff in Blakenhurst to manage the man in an appropriate way. There was continuity of care between the man's community psychiatric team and the in-reach and forensic mental health teams.
70. My investigator asked the PCT to conduct the review on 29 September 2004 but it was not received until 4 October 2005.

Consideration and conclusions:

71. The man presented with a range of complex physical and psychological difficulties when he was located in Blakenhurst and many staff were in charge of his care. It is not clear whether any effort was made to ensure that he took exercise and it appears that he spent most of his time lying down in his cell. In view of his medical condition and the medication he was taking, it would have been important for him to take exercise although it is impossible to say what difference this would have ultimately made to the man's wellbeing.
72. The man's cousin expressed concern about the role of the various psychiatric teams involved in his cousin's care before he was located in Blakenhurst. He also felt that the police acted inappropriately in arresting the man considering his obvious mental health problems. The man's cousin criticised the role of the hospital from when the man was admitted on 3 September until his death on 9 September. He questioned why the man was allowed to refuse medication, food and water, and whether he should have been sectioned under the Mental Health Act to ensure he complied with his treatment. These issues are outside my remit, but the family may decide to pursue them via the NHS complaints system.
73. During his time in hospital, the man was handcuffed to a prison officer and, generally, two other officers were present at all times. The man's cousin was unhappy that his cousin's freedom of movement during his last days was curtailed in this way. I can appreciate that this must have been very distressing for the family, but I am satisfied that the prison authorities undertook a proper risk assessment based on the necessary and available information. I believe that the risk assessment was appropriate in view of the man's previous violent behaviour.
74. The man's cousin also expressed disappointment at the lack of contact from the prison after the man's death. When this report was produced in draft form, my investigator had not yet received a full reply from the prison to her inquiries about the alleged lack of contact. Nevertheless, the prison maintain that there was contact with the family and that funeral expenses were paid. Given the time that has already elapsed since the man's death, I do not wish to increase the delay in issuing this report still further.
75. The man's cousin was very concerned that the man was in prison and not located in a secure psychiatric hospital. He said that he spoke to the man's solicitor and healthcare staff on several occasions to ask whether the man could be transferred to a secure psychiatric hospital, but nobody took any action. It is clear (and was acknowledged by various people involved in the man's care) that the segregation unit was not the most appropriate place to manage the man. It was also noted in his records that his mental health generally deteriorated when he was located there. However, neither the normal location house blocks, nor the lower medical, were considered appropriate locations due to his aggressive behaviour.
76. As his mental health continued to deteriorate, the man had more frequent assessments by his psychiatric teams. As detailed earlier, attempts were made to obtain a suitable placement for the man outside Blakenhurst, preferably in a secure psychiatric hospital. Given the man's physical and mental health difficulties, the

decision about where to locate him was difficult to make and finely balanced. Given the evidence of what attempts were made to find a placement for him outside the prison, I conclude that those efforts were reasonable.

77. There is no doubt that the symptoms of mental illness the man was exhibiting became the focus of concern, and I can readily appreciate why this was. However, it is impossible to say whether earlier treatment would have prevented his death. I note that the man had complained of a sore arm on 7 August and a sore leg on 2 September. But it is not clear from the records whether he received treatment for either complaint, and he had a chest infection by the time he was admitted to hospital. It does not appear either that he saw a counsellor specifically to deal with his bereavement as identified in his care plan. It is also difficult to identify from the records exactly when he was located in healthcare at the end of August.
78. **I recommend that healthcare staff endeavour to provide a more holistic approach to care to ensure that all the patient's needs are met - clinical and psychological - including counselling, if appropriate.**
79. **I recommend that healthcare staff are reminded of the need for clear, concise and contemporaneous record keeping in accordance with the Nursing and Midwifery Council guidelines for records and record keeping. A clinical audit system must be put in place to monitor compliance with these standards for records and record keeping.**
80. **The Governor should remind all staff of the need to ensure that contemporaneous prisoner records are maintained and updated particularly to reflect decisions taken or considered and all prisoner movements.**
81. A F2052SH was opened when there was concern during a MAPPA meeting about the man's possible reaction to the realisation that he had been responsible for his mother's death. It was closed after about 10 days before being re-opened five days later at the advice of the MARC team. I have considered whether the F2052SH should have been closed at all. However, at that time the man had not expressed any suicidal or self harm intentions and there were no other indications that he was at risk. Consequently it was appropriate for staff to close the form. Nevertheless, I have detailed at length the range of issues involved in caring for the man in a custodial environment. My overriding view is that prison was not a suitable location for him.

Recommendations:

OPERATIONAL:

The Governor should remind all staff of the need to ensure that contemporaneous prisoner records are maintained and updated particularly to reflect decisions taken or considered and all prisoner movements.

HEALTHCARE:

I recommend that healthcare staff endeavour to provide a more holistic approach to care to ensure that all the patient's needs are met - clinical and psychological - including counselling, if appropriate.

I recommend that healthcare staff should be reminded of the need for clear, concise and contemporaneous record keeping in accordance with the Nursing and Midwifery Council guidelines for records and record keeping. A clinical audit system must be put in place to monitor compliance with these standards for records and record keeping.

The Prison Service has accepted all the recommendations. The man's cousin responded to the draft report and maintains that there was no contact from the prison after the man's death and has also said that he has not received reimbursement for the funeral costs. The man's cousin asked what had happened to money left in his cousin's prison account and finally he believed there should be some books belonging to his cousin at the prison.

The prison does not have a record that anybody from the establishment contacted the man's family after his death. With regards to the funeral cost, the Governor has agreed to pay the amount requested and is liaising with the man's cousin about this matter. When the man died, he had a balance of £51.58 in his account, which is held in a suspense account at the prison. The prison could not find any books belonging to the man at the establishment.

I would remind the prison that in future, they should allocate a Family Liaison Officer and such matters should be dealt with in a timely and sensitive manner and suggest that the cash in the man's account should also be reimbursed.

