Investigation into the death of a man in October 2004 at HMP Manchester

Prisons and Probation Ombudsman for England and Wales

August 2006

This is the report of an investigation into the death of a man at HMP Manchester in October 2004. He was found hanging in his cell in the segregation unit during the afternoon of that day.

I wish to offer my sincere condolences to the man's family and friends for their sad loss. I know the staff and prisoners at Manchester who knew him share those sentiments.

The investigation was undertaken by my Deputy Ombudsman assisted by a governor from HMP Durham and a clinician identified by my office. I would like to thank the Governor of Manchester and his staff for their participation in this investigation.

The man at the centre of this report appeared to be troubled whilst he was in prison, but did not share his worries with staff and gave no indications that he was intent on taking his own life. Whilst I do not believe that staff could have predicted the events of 13 October, I make three recommendations designed to improve safety at Manchester prison**.**

I regret the delay in bringing this report to fruition. The man's death occurred before 1 December 2004 when interim arrangements for the investigation of deaths in custody, agreed between my office and the Prison Service, were still in place.

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

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Summary

This man was born in Manchester, and lived in the Manchester area all his life. At the time of his reception into prison on remand in February 2004, he was 25 years old. This was not his first period of imprisonment.

Until early October the man had a fairly unremarkable period in prison. He had gained employment as an industrial cleaner and was well liked on his residential unit. From the transcripts of the man's telephone calls, it is known that he was troubled by what he perceived to be events going on at home in his absence. But he never sought help from staff or articulated his worries to staff. He was also concerned about his partner's pregnancy and was supported and reassured by staff on this matter. Additional phone calls were arranged and staff also made calls to check on his partner's welfare.

In early October, intelligence had been received that the man was dealing drugs on the wing. A search on 12 October revealed 17 wraps of a brown substance, now known to be heroin, secreted on his person. He was charged under Prison Rule 51, paragraph 12 – has in his possession any unauthorised article. The adjudication commenced at 10.30am on 13 October. The man pleaded not guilty to the charges and asked for permission to contact his solicitor. He also requested that he call his cellmate as a witness. A prison governor appropriately adjourned the adjudication to enable the man to contact his solicitor. He also felt it appropriate to refer the case to the police. There is no evidence to suggest that the referral to the police took place before the man apparently took his own life later that day. At no stage did the police see or question the man about the drugs found on his person the previous day. The prison governor said that the man did not present as particularly distressed or troubled at the disciplinary hearing.

Following the adjournment the man was free to return to the wing. On the way back to the wing, he told an officer that he wanted "to talk to somebody, about the lads who gave me the drugs". Arrangements were made for him to talk to a source handler under the informant scheme that afternoon. He was therefore moved back to the segregation unit for his own protection and to facilitate the meeting with the handler. Unfortunately, the handler has left the service and it was not possible for us to interview her. The notes of the interview were located and have been read as part of my investigation and these refer to security matters.

Shortly after 4pm on 13 October, the man was found suspended by a ligature in his cell in the segregation unit. Efforts were made to resuscitate him, but sadly these were unsuccessful and he was pronounced dead just before 4.30pm.

Investigation methodology

1. My Deputy Ombudsman opened the investigation on the very day of the man's death, as she was at HMP Manchester investigating another apparently self-inflicted death. She met with the Governor, deputy governor and the Independent Monitoring Board. She later met with representatives of the Prison Officers' Association. A clinical review of the care and management of this man was carried out by a clinician on behalf of my office.

2. Notices were later issued to staff and prisoners explaining the nature and scope of the investigation and encouraging anyone who wished to submit information about the man's death to make themself known to the investigation team. Nobody came forward as a result of these notices.

3. The clinician and a governor at HMP Durham assisted with the investigation, carrying out a number of interviews with relevant staff and exploring a number of issues that arose as a result of the investigation. The team returned to Manchester in early January 2005.

4. The police attended the prison after the man's death and carried out their own investigation. They concluded that there were no suspicious circumstances nor any third party involvement.

5. During the course of the investigation one of my Family Liaison Officers met with the man's partner, mother and sister to explain the scope and nature of the investigation and identify any concerns they had about the man's time in prison. The family were particularly concerned about a telephone conversation that occurred the night before the man's death. During this conversation, he had stated that another prisoner had been pressuring him for his PlayStation.

6. I hope this report provides answers to the questions raised by the man's family.

HMP Manchester

7. HMP Manchester is a high security local prison. It is situated just outside Manchester city centre and is part of the high security directorate within the Prison Service. The prison is generally regarded within the Prison Service as a progressive and well managed establishment.

8. Manchester operates under a Service Level Agreement (it is therefore managed under similar lines and protocols to private prisons and subject to the same performance monitoring procedures). The prison's certified normal accommodation is 961 and its operational capacity (maximum crowded capacity) is 1,261.

9. The last standards and security audit rated the establishment at 87% for Standards and 95% in Security. When considering the specific performance issues that are key to the care of prisoners, the audit scores were 95% for suicide prevention, 58% for safer establishments (anti-bullying), 88% for health services to prisoners, and 94% for prisoner induction. With the exception of anti-bullying, these scores are all in the good range.

10. The most recent inspection of Manchester by HM Chief Inspector of Prisons was in 2001. The inspection report concluded that, "there was much good about the cultures and priorities of Manchester prison. It was certainly not a prison giving major cause for concern; indeed the flexibility and positive approach of staff and managers, and their achievements against considerable pressures are a lesson to many other local prisons."

11. This man's death was the third of four apparently self-inflicted deaths at HMP Manchester between September and November 2004. I have not identified a link between the deaths, nor have I found common causal factors or management failings that contributed.

Events during the man's period in custody: 26 February – 13 October 2004

12. The man appeared at Stockport Magistrates' Court on 26 February 2004, charged with a number of offences including burglary and robbery. He was remanded into custody and his case was referred to Manchester Crown Court for trial. HMP Manchester did not have any available beds that day and thus was unable to take any new receptions from the courts. The man was taken, therefore, to HMP Liverpool.

13. On reception into Liverpool, the man underwent the usual new reception screening procedures, including an assessment by healthcare staff. He did not report any history of self-harm, mental illness or substance misuse. I note there are no entries in his clinical record or wing history sheet to indicate how he settled down or if there were any specific problems that arose in his first few days in prison.

14. On 4 March, the man appeared at the Crown Court and was again remanded into custody after a short appearance in which he confirmed his name and address and had the charges against him read out. His trial date was not set at this stage, but was to be on a later date to be notified by the court. This time, the man was taken to HMP Manchester where he arrived shortly after mid-day. He was seen in reception and, as he had already been in prison in Liverpool, was appropriately treated as a return from court rather than a new reception. However, there is no evidence in the clinical record that healthcare staff saw the man as required by healthcare standards. He was initially located on G wing - the induction unit at Manchester.

15. Once on G wing an officer saw the man and carried out the initial risk assessment. As noted, on reception into Liverpool, the man had denied any history of deliberate self-harm. However, during this assessment at Manchester, he stated he had cut himself and tried to hang himself some 18 months earlier. The officer correctly established that the man had no current thoughts of deliberate self-harm and would approach staff if he felt low and depressed. Consistent with the assessment of risk, it was not felt necessary to open an at risk of self-harm document (F2052SH). The man's main concern during this interview was that his family did not know where he was. The officer therefore made arrangements to contact the man's partner to tell her that he was in Manchester. The man's partner was able to visit him the following week.

16. On 23 and 27 March, the man was warned about his behaviour. He was found hiding in another cell when staff were trying to get exercise underway and lock up those who did not wish to participate. However, there are no entries in his wing record to indicate that he was not settling down to the prison routine.

17. On 24 April, the man was seen by healthcare complaining of toothache. He was issued with simple painkillers and advised to see the doctor the following day. This is supported by an entry in his continuous medical record. The following day, the prescription chart indicates that he was prescribed and issued with antibiotics, presumably for a dental abscess. The lack of an entry in the

continuous medical record does not enable us to confirm that he was seen by the doctor or the exact reason for the prescribing of the antibiotics.

18. On 29 April the man was seen by a doctor. He was complaining of feeling worried and not being able to sleep properly. The doctor felt it appropriate to prescribe the man a mild anti-depressant (citalopram) and agreed to review him again in two weeks. The man's medical record does not indicate that the citalopram was in fact prescribed or that he was reviewed, as agreed, two weeks later. Furthermore, a lack of entries in his wing record means we can know little about the man's demeanour or emotional well-being whilst on the residential units. However, it is known that healthcare staff contacted the chaplaincy team requesting they see the man. A lady agreed to see him later that day.

19. The man expressed concern to staff on 13 June about his partner's pregnancy. An officer contacted his partner and established that, whilst there were problems, she was 'alright'. The officer passed this information on to the man and reassured him.

20. The lady from the chaplaincy team saw the man again on 29 June. He was tearful and anxious, particularly about his forthcoming trial and his partner's pregnancy. The man expressed concerns about the future, but was adamant he was not contemplating suicide. The lady from the chaplaincy team considered raising an F2052SH document but, on the available evidence, did not consider it appropriate at that time. She reassured the man and informed him that the chaplaincy team were available if he wanted to talk.

21. The man appeared at Manchester Crown Court on 1 July. He pleaded guilty to the charges, as advised by his solicitor, and received a sentence of three and a half years. He returned to Manchester that day. There is no indication in the medical record that he was reviewed by healthcare staff on his return from court or that the change in status from remand to convicted was noted.

22. On 2 July the man saw his doctor again as he was finding it hard to get up in the morning to collect his daily dose of citalopram. The entry by this doctor notes that the man said he had seen him two days earlier. Whilst there is no entry to support this, there is a prescription signed and dated 29 June by the doctor for the daily issue of citalopram 10mg. Following the consultation on 2 July, the doctor adjusted the man's prescription to in-possession and the man was issued with a 28-day supply.

23. An entry in the man's wing record, dated 26 July, notes that he could not move to D wing whilst another prisoner remained on that wing. There is no indication of the reason for this decision or any documented security intelligence to explain the nature of the problem.

24. On 29 July, the doctor doubled the man's dose of citalopram. The man had told him that, whilst initially he had felt more relaxed and less preoccupied with his problems, this had 'stalled'. The doctor arranged to review him again after three months on this increased dose. The man's prescription for citalopram was repeated on 13 and 24 August and again on 29 September.

25. The man moved to A wing on 11 August. He was located in a cell with another man; both were identified as low risk using the cell sharing risk assessment, and therefore considered suitable to share a cell. They appeared to get on well and settled down to the wing routine. Two weeks later, the man had gained employment in workshop one and later went on to gain a Foundation Award for professional cleaning.

26. On 8 September, the man appeared at Manchester City Magistrates' Court for an outstanding burglary charge. He was sentenced to four months imprisonment to run concurrently with his current sentence. This meant his overall sentence length was not affected and his conditional release date remained as 25 November 2005.

27. The following day, an officer arranged for some emergency credit to be put on the man's phone account as his partner was being admitted to hospital due to complications with the pregnancy.

28. During routine searching on 22 September, home brew ('hooch') was found in the cell occupied by the man and his cellmate. The cellmate admitted responsibility. He had in fact previously been found in possession of 'hooch'. The man was not charged under Prison Rules for this offence.

29. During routine cell fabric checks, another officer removed pictures from the back of the cell door belonging to the man and his cellmate. Having pictures on the back wall was against wing rules (indeed, it is a basic security requirement in all prisons that exterior walls should not be obscured). Nevertheless, the man was annoyed with this officer, swearing at her whilst expressing his displeasure with her actions. The same day, a further entry in his wing record notes that in a recording of a phone call from the previous day, the man was heard to say to his partner that he had rung someone the last night using somebody's mobile phone. A security intelligence report was submitted and the wing Principal Officer warned the man about his behaviour. However, no further action was taken.

30. Intelligence had been received that the man was dealing drugs on the wing and a search on 12 October revealed 17 wraps of a brown substance, now known to be heroin, secreted on his person. The man was charged under Prison Rule 51, paragraph 12 – has in his possession any unauthorised article – to appear before an adjudication (prison disciplinary hearing).

Events of 13 October and after

31. The man was issued with his adjudication paperwork at 8.30am on 13 October 2004 by an officer. The record of the adjudication shows that one of the prison's governors was adjudicating that day. The paperwork does not indicate that the man was seen by a healthcare worker or doctor and assessed for his fitness for cellular confinement, should that be the chosen punishment, prior to the adjudication. There is also no available segregation algorithm, indicating the man's fitness to be held in the segregation unit, as there should be in accordance with segregation rules.

32. The adjudication commenced at 10.30am. The man pleaded not guilty to the charges and asked for permission to contact his solicitor. He also requested that he call his cellmate as a witness. The adjudicating governor appropriately adjourned the adjudication to enable the man to contact his solicitor, and also because he felt it appropriate to refer the case to the police. There is no evidence to suggest that the referral to the police took place before the man apparently took his own life later that day. At no stage did the police see or question the man about the drugs found on his person the previous day. The governor said that the man did not present as particularly distressed or troubled at the hearing.

33. Following the adjournment, the man was free to return to the wing. At about 12.30pm, an officer went to the segregation unit to collect him and take him back to A wing. On the way back to the wing, the man told this officer that he wanted "to talk to somebody, about the lads who gave me the drugs". The man felt he was now in debt, with no way of getting the money to pay off the debt. The officer discussed the options with him and the man agreed to speak to the Senior Officer and also the informant manager. The man returned to the wing and was locked in his cell with his cellmate; during the lunchtime lock-up period they played scrabble. According to the man's cellmate, he did not appear distressed or fearful nor show signs of being suicidal.

34. Over the lunchtime period, arrangements were made for the man to be re-located in the segregation unit for his own protection and to be interviewed under the informant scheme. At 1.50pm, before the rest of the wing was unlocked, he was returned to the segregation unit.

35. During the afternoon, a further officer saw the man under the arrangements for the informant scheme: from the security information report it appears that this was about 2pm. Following this interview, a female governor asked the officer to complete a security information report regarding the information the man had given her 'warts and all'. This completed security report was passed to the female governor, who manages the informant scheme. The contents of the Security Information Report have been seen by myself and refer to security matters.

36. It has not been possible to establish what happened to the man immediately after the interview or what his state of mind was. However, the genuine shock of staff

on learning that the man had apparently taken his own life indicates that staff did not perceive him as at risk of suicide.

37. At approximately 4pm, an officer was alerted by the prisoner he was escorting on the exercise yard that there was a knotted sheet at the window of cell number 11. The officer saw what he described as a green sheet attached to the outside of the window, which appeared to be being stretched and bearing some weight. He immediately ran from the exercise yard and up the stairs to the landing and opened the cell door flap and saw the man with the sheet tied around his neck, suspended from the window bars. The officer then immediately summoned help and entered the cell to support the man's weight until other staff arrived and helped remove the ligature.

38. At approximately 4.10pm, a nurse and an agency nurse responded to a Hotel 1 radio call to attend the segregation unit. Another nurse from healthcare contacted the segregation unit for more information in order to make a judgement if further medical support was required. On hearing that it was a hanging, she made her way to the unit to assist the others already in attendance. Cardio Pulmonary Resuscitation (CPR) was commenced in an attempt to restart the man's heart. The staff continued for 15 minutes to try to resuscitate the man. The man's doctor arrived at about 4.25pm and made a clinical assessment of the situation, pronouncing life extinct at 4.27pm.

39. Following the man's death, the police attended and established that there were no suspicious circumstances or third party involvement.

40. A governor was asked by the governing Governor to break the sad news to the man's family, along with a minister from the chaplaincy. The governor and this minister initially went to see the man's partner and her family and, despite the family's obvious distress, they were made to feel welcome. The man's partner told them she was concerned about a telephone call she had received the previous evening when the man had expressed concern about being pressurised by another prisoner for his PlayStation. After spending some time with the man's partner and answering the questions that they could, the governor and the minister went to see his mother and sister. The family found it difficult to understand why the man had taken his own life. The governor left contact details, advising the family that they could contact him at any time.

41. Following the initial visit, the governor contacted the family a couple more times and ensured that the man's property – including the PlayStation - was returned to them.

The man's clinical care

42. On reception into prison, the man stated that he was not registered with a GP and reported neither significant illness, injury or any history of self-harm, substance misuse or mental illness. Whilst in prison, he saw the medical officer on a number of occasions. The man's anxiety and insomnia were correctly identified by the primary care team, and managed as they might have been in the community.

43. On the man's transfer from Liverpool to Manchester, there was no further reception interview. There is also no documentary evidence to show that the man was seen and assessed by healthcare after he had been sentenced to three and a half years.

44. The recommendations of the clinical review include consideration of regular clinical audit to monitor compliance with:

    - published local and national policies and procedures
    - standards of records and record keeping.

45. Whilst finding no fault with the response of the nurses to the emergency, the clinical review draws attention to there being no system in place to differentiate the level of emergency requiring healthcare attendance and clinical support. This has been reviewed locally and a call system implemented to summon healthcare to critical emergencies and enable the most efficient and timely response. I commend Manchester's prompt action.

Issues considered during the investigation

Management of the informant scheme

46. A Senior Officer contacted the governor overseeing the informant scheme after an officer alerted her to the man's wish to talk to someone about the intelligence he had. The SO subsequently made an entry in the man's wing history sheet alluding to his having become an informant. This was promptly accepted by prison managers to have been an inappropriate course of action. The security department immediately ensured that managers were reminded of the degree of confidentiality needed to ensure the integrity of the informant scheme.

47. The man was advised of what would happen next and the level of protection that would be afforded to him. He was therefore moved back to the segregation unit for his own protection and also to facilitate the meeting with the officer acting as source handler.

48. During the afternoon of 13 October, the man was seen by the officer acting as source handler on behalf of the system manager. Unfortunately, as this officer left the Prison Service for a new career shortly after the man's death, it has not been possible to ascertain exactly what was said or went on during her interview with him. It is known that the governor overseeing the informant scheme asked her to write up her interview, 'warts and all'. This governor had not opened a file on the man and could not locate the security / interview report at the time of the draft report, but this has now been located and read as part of the investigation.

    Staff should be reminded of the importance of ensuring that all written records are saved and filed appropriately after a death in custody.

49. It was acknowledged by the governor overseeing the informant scheme that there had been some failings in the management of informants. I understand that steps have been taken to review the system and rectify identified shortcomings.

Allegations of bullying

50. The man's family expressed concerns that the man was being bullied by another prisoner, in particular for his PlayStation. Analysis of the transcripts of the man's telephone calls shows that he did express concerns to his partner about 'a bit of trouble…' with 'some black guy…' regarding a 'computer' (a reference meaning his PlayStation). His partner said that this phone call occurred on the evening of 12 October. The man did not express his concerns to any members of staff or any anxieties to his cellmate. The cellmate said that he had heard that the man was being bullied, but had not had it confirmed.

51. Whilst the man clearly expressed to his partner that he had 'a bit of trouble', it has not been possible to substantiate that he was in fact being bullied by another prisoner or prisoners.

The man's involvement in the prison drug culture

52. The man did not have a history of involvement in drugs and denied on his reception interview that he had ever taken drugs. There is no clinical evidence to suggest that he had a history of substance misuse. Furthermore, his previous convictions do not suggest that his criminal activities were related to supporting a drug habit.

53. According to the man's cellmate, the man had discussed with him the idea of holding drugs. The cellmate did not feel that the man fully understood the potential consequences if he was caught. The man's prison discipline record and security file do not suggest that he was involved in the drug scene (that is, until the intelligence leading to the search that led to the significant find of heroin). His cellmate was not aware that he was holding the drugs until they were found on 12 October.

54. The man's cellmate said the man told him 'he had to do it', but did not elaborate as to the reasons why. The absence of the security / interview report by the informant officer makes it impossible now to say why the man got involved in the local drug culture by holding class 'A' drugs. However, it is known that the information he provided led to the actual owner of the drugs being identified.

Clinical care

55. The man's anxiety and insomnia were correctly identified and managed as they might have been in the community. However, no referral was made to the mental health in reach team. This was due to restrictions imposed by the national funding arrangements which meant the focus of the service was on severe and enduring mental illness. Since the man's death, the emphasis on severe and enduring mental illness on the part of the mental health in reach team has been relaxed. Coupled with the recruitment of primary care mental health nurses, and the anxiety management groups in the day care centre, I understand this has enabled prisoners with other mental illnesses to be more effectively managed on a day to day basis.

56. The clinical review identified a number of shortcomings in the standards of records and record keeping. Clinical records are an important source of information for the care and management of patients amongst the multi-disciplinary team. An audit of clinical records would reduce the possibility of gaps and inconsistencies in records, such as was found in this man's case. There is a significant lack of concurrence between entries in the continuous medical record and prescription charts. There are also contradictions between the various documents. These issues are further discussed in the clinical review.

    A system of clinical audit should be put in place to monitor the standards of records and record keeping. This should also form part of the clinical governance arrangements for the prison and PCT partnership.

57. There is a requirement - under local policy and national healthcare standards - for prisoners to be seen on transfer and also when they are subject to a change of

status. Following this man's transfer to Manchester and his return to custody after court appearances, particularly after sentencing, there is no documentary evidence to show him having been seen and reassessed. The aim of these assessments is to establish any changes in physical and mental health and, if necessary, develop a plan of care to meet the new and current health needs of the patient. Whilst I do not believe it would have affected the eventual outcome with regard to this man, it could have significant implications for others.

A clinical audit system should be put in place to monitor compliance with published and operational policies and procedures such as the reception and discharge policy.

58. The clinical review makes reference to reviewing the system for summoning medical assistance to critical emergencies to ensure an efficient and timely response. I am aware that Manchester have reviewed the system in use at the time and introduced a system to differentiate between the levels of emergency.

The man's contact with his family

59. The man clearly had a caring and supportive partner and family; he phoned home regularly to speak to his partner. Transcripts of these telephone conversations show that the man was anxious to find out what was going on at home. The family said that this was nothing unusual, as he regularly phoned his partner, even when he was not in prison. This was as he needed constant reassurance about her whereabouts and what she was doing. He also received regular visits from his partner, his two daughters and his mother. He always looked forward to these regular visits. The man's cellmate said he 'was happy after visits'.

60. The man was obviously worried about his partner and the problems she was having with the pregnancy. Staff facilitated additional phone calls for him, as well as contacting his partner on occasions. The man spoke to the chaplaincy about his worries and they provided him with reassurance and support.

61. I conclude that staff did much to support the man through what was obviously an emotional and troubling time for him. I especially commend the actions of two particular officers (see paragraphs 20 and 32 above) and would be grateful if the Governor could share my comments with them.

62. Consideration was given on two occasions to opening a suicide and self-harm warning form for the man. However, given the information to hand, and the man's assurances that he was not suicidal, I have no criticism of the decisions not to open such forms.

Conclusions

63. The man was clearly troubled by what he perceived to be events at home and his partner's pregnancy. Evidence from telephone calls suggests that he was also being pressurised to hand over his PlayStation to another prisoner. However, it is not possible to establish why or how long this had been going on, and the man did not share his worries with staff or his cellmate. He appeared settled on the wing and worked as an industrial cleaner. There was no indication to staff or others that he was in fact feeling suicidal. The man's cellmate said he felt the man was 'not the sort to be bullied', and was a popular man on the wing.

64. The man had also got involved in the local prison drug scene, although it is not possible to determine his reasons for doing so or if he really understood the consequences of his actions. However, he was so concerned about the situation he found himself in on 13 October that he asked to become an informant. The informant officer's resignation from the Prison Service has meant we have been unable to gain a full understanding of what went on during the afternoon of 13 October, or of the man's emotional state when she had finished her interview with him.

65. At his adjudication on the morning of 13 October, the man had not appeared particularly distressed and did not present as an especially troubled individual. The adjudication was appropriately adjourned for referral to the police due to the quantity of drugs involved. However, at the time of the man's death, the case had not been referred and he had not been seen by the police.

66. The man had been chatting to an officer about his future after the adjudication. Over the lunchtime lock down, he had played Scrabble with his cellmate and not shown any signs of distress or anxiety.

67. On two occasions, the opening of a suicide and self-harm monitoring document had been considered. However, given the available evidence, the decision not to open this document was appropriate.

68. The management of the informant system appears to have been unsatisfactory at the time of the man's death. This was recognised by management at Manchester and prompt action was taken to rectify these issues identified and to reinforce the importance of confidentiality.

69. It is not possible to determine exactly why the man chose to take his own life. It is probable that he was troubled by a number of things. He did not share these feelings with staff or other prisoners, nor did he display behaviours or attitudes that would have alerted either staff or prisoners to his being at risk of suicide or self-harm. Only hours before he took his own life, he talked positively about the future and had taken a conscious decision to supply the prison with security intelligence regarding the use and supply of drugs.

Recommendations

Staff should be reminded of the importance of ensuring that all written records are saved and filed appropriately after a death in custody.

A system of clinical audit should be put in place to monitor the standards of records and record keeping. This should also form part of the clinical governance arrangements for the prison and PCT partnership.

A clinical audit system should be put in place to monitor compliance with published and operational policies and procedures, such as the reception and discharge policy.