# Investigation into the circumstances surrounding the death of a man, a prisoner at HMP Lewes, who died in January 2010

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

**November 2010**

The man was 46 years old when he was found dead on 2 January 2010, in his cell at HMP Lewes. He had made a number of cuts to his arm, including to a main artery, and had apparently bled to death. The Senior Investigator, Family Liaison Officer, and I offer our sincere condolences to his family and friends for their sad loss.

I wish to thank the Governor of HMP Lewes for making the necessary facilities and information available to the investigator. I also thank the prison Liaison Officer, a Senior Officer, and another member of staff for their assistance.

In the course of the investigation, I asked for a clinical review to be carried out into the medical care and treatment of the man received while he was in custody. A doctor was appointed by the Deputy Head of Clinical Governance, NHS Hastings and Rother and NHS East Sussex Community Health Services. I am grateful for their assistance and the doctor's report. The doctor is a consultant forensic psychiatrist with experience of providing mental health services into the prison environment.

The man was on remand, awaiting trial for various alleged offences committed against members of his family. In themselves, offences against family members heighten the risk of self harm. Anxieties about the forthcoming trial might also have been a cause of concern for the man. I am pleased to see that, as a result of the man's death, these issues were highlighted to all prisons, so awareness of these risk factors should now be raised across the prison estate.

I make ten recommendations. The recommendations relate to local suicide and self harm procedures, healthcare assessment, resuscitation procedures and record keeping. I also invite the East Sussex Downs and Weald Primary Care Trust to commend nursing staff for their attempts to resuscitate the man.

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**Acting Prisons and Probation Ombudsman** **November 2010**

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**SUMMARY**

The man was remanded into prison custody on 21 April 2009 having been charged with perverting the course of justice. In May that year he was charged with the murder of his daughter, who had disappeared in 2008. The man's trial was due to begin on 4 January 2010 at Lewes Crown Court. It was regarded as high profile in Sussex and often reported by local media. .

Imprisonment was not a new experience for the man. He had previously served just over three months of a six month sentence for a firearms offence, although not recently.

Although not known to community psychiatric services, the man told a nurse at the prison that he had experienced psychological problems following major heart surgery. When he arrived at the prison it was noted that he had thoughts about harming himself whilst at court and, as a result, he was monitored under the Prison Service suicide and self harm procedure.

The man continued to be monitored and supported by healthcare and appeared to have settled down. Staff therefore stopped monitoring him closely in July 2009. He had a small circle of friends of a few other prisoners but had not shared his suicidal thoughts with them. Although he did allude to cutting himself, it was not taken seriously.

On 2 January 2010, at about 10.15am, the man's cell was unlocked, along with those of other prisoners. The officer who unlocked the doors did not go into the cells, but merely ensured the doors were unlocked to allow the occupants to leave.

About one hour later, a prisoner went to his cell and found him dead on his bed. When prison staff and medical staff attended it was evident to them that the man had been dead for some considerable time as rigor mortis was clearly evident. Despite this, nurses attempted resuscitation in the belief that had they not done so, they could have been disciplined by their employers. The man had cut his arms and apparently bled to death.

As a result of this investigation, I make ten recommendations. These concern the suicide monitoring and healthcare procedures at Lewes.

## THE INVESTIGATION PROCESS

1. After receiving notification from the Prison Service on 2 January that the man had died. The Senior Investigator was appointed to carry out the investigation. The investigator contacted the prison and arranged to travel there to open the investigation.

2. On 13 January, the investigator opened the investigation by meeting the Governor. He then met two officers both representing the local Prison Officers Association (POA), the Safer Custody Manager, the Head of Healthcare, a Community Psychiatric Nurse (CPN), the Head of Residence, and Safer Custody Coordinator. The Safer Custody Coordinator was also appointed to act as the prison's liaison officer.

3. Following that meeting, and at her request, the investigator met with the CPN separately. She had been asked to hand the investigator a report compiled for the East Sussex Community Health Services which gave a chronology of specific events relating to the man from the date he arrived into prison custody. The investigator forwarded the document to the clinical reviewer.

4. At the end of the meeting, the investigator was taken to the cell where the man had died. The cell (M3 – 02) is located on the fourth landing of Sussex Wing and, at the time of his visit, it was unoccupied but had been cleaned. It is a single occupancy cell.

5. In addition to viewing the cell, the investigator asked to examine the prison telephone computer system and identify any telephone calls made by the man. As there were a large number of telephone calls, he asked for a copy of the man's telephone calls from 21 December to his final call on 29 December to be downloaded and made available. He also asked that all available telephone calls be downloaded and secured at the prison in case it was necessary to listen to them at a future date. I understand the computer system is capable of storing calls from the previous 90 days, after which it automatically removes any records. The downloaded telephone calls cover the period 16 October to 29 December 2009.

6. On 14 January and before leaving the prison, the investigator met the Governor to discuss what he had done since arriving at the prison. The investigator explained that he would return the following month to begin interviewing a number of staff who he had identified as being able to assist.

7. The following month, the investigator returned to the prison to continue his investigation. After completing his work, the investigator met the Deputy Governor and reported his findings.

## HMP LEWES

8. HMP Lewes is a category B local prison for sentenced and remanded adult male and young offenders which is situated close to the town centre. Built in 1853, it serves the courts of East and West Sussex.

### Her Majesty's Chief Inspector of Prisons

9. Her Majesty's Chief Inspector of Prisons reports on all Prison Service establishments. Inspections are either announced and allow the prison being reported on to prepare for inspection, or unannounced.

10. In November 2007, the Chief Inspector of Prisons issued a report following an announced inspection carried out in August that year. In her introduction, she said that relationships between staff and prisoners were "extremely good", adding that this was the prison's great strength. She went on to say that there was evidence that staff knew about, and engaged with, the prisoners in their care, though the knowledge was not effectively put to use in resettlement and suicide prevention work. The Chief Inspector of Prisons said the prison was reasonably safe but had some "worrying weaknesses in anti bullying and suicide prevention procedures".

11. In concluding her introduction, the Chief Inspector of Prisons said that, overall, Lewes was a decent and safe prison. She said this owed a great deal to the positive approach of staff and managers.

12. Under the section covering suicide and self harm, the Chief Inspector made six recommendations, aimed at improving procedures. This report has identified no similarities between those recommendations and the findings of this investigation.

### Independent Monitoring Board (IMB)

13. Each prison has an Independent Monitoring Board (IMB) and their role is to monitor the prison and report any concerns that they have regarding the prison, or how prisoners are treated. In the first instance, the Board report to the Governor, or, if considered necessary, it can report directly to Parliament. Board members are able to visit any area of the prison at any time and have direct access to any prisoner who they wish to see, or who requests to see them. The Board holds regular meetings in the prison, with the Governor attending for part of the meeting. The Chairperson of the Board produces an annual report to the Secretary of State for Justice.

14. In its latest report, covering the period 1 February 2008 to 31 January 2009, the Board said management and staff had been resourceful in juggling the demands of a busy local establishment. They went on to say that there was real improvement taking place and hoped adequate funding would be available to fulfil the initiatives and programmes. The Board acknowledged an improvement in safer custody procedures and said all aspects of safer custody are taken seriously at Lewes.

## Prison officer grades

15. At the time of the man's death there were three levels of uniformed prison officer grades. Prison officers are front-line supervisory staff and, in the majority of cases, prisoners have first and most contact with them.

16. Senior Officers (SOs) are the first grade of managers and act as a reference point for prison officers. SOs are responsible for the day-to-day management of their area, supervising staff and dealing with issues raised by prisoners.

17. Principal Officers (POs) were the highest rank of the uniformed staff. They supervised other uniformed staff and had operational responsibility for the prison.

18. In addition to prison officers, there are a group of staff known as Officer Support Grades (OSGs). OSGs wear prison uniform and carry keys but do not carry out the same function as prison officers. Their role is to support the areas of the prison that have little or no prisoner contact, for example, the gate. They are often on duty at night when they monitor specific prisoners and carry out roll checks.

## Cell sharing risk assessment (CSRA)

19. All prisoners are subject to a Cell Sharing Risk Assessment (CSRA) on reception. The CSRA process is designed to assess the risks posed by an individual to other prisoners which includes taking into account the situational context of any previous violence. As assessment takes place before a prisoner spends their first night in custody (with the exception of open prisons) and triggers a risk minimisation plan for those identified as high or medium risk which is reviewed at regular intervals.

## Sussex wing

20. Sussex Wing is a purpose built house-block and opened in 2008. Although it is also known an "L and M" wing in the prison, but for the purpose of this report I refer to it as Sussex Wing. It provides single cell accommodation for 174 prisoners considered to be vulnerable either as a result of their offence, or because they are unable to cope in the main prison. It provides an integrated regime where all those on Sussex Wing live together and are not separated.

## Healthcare

21. Healthcare services, including a 19 bed inpatient unit, are commissioned by East Sussex Downs and Weald Primary Care Trust. Healthcare services are provided by East Sussex Community Health Services which has been an arm's length organisation from the primary care trust since April 2009.

**Prison Service Orders (PSO)**

22. Prison Service Orders are long term instructions which are intended to last for an indefinite period. Any mandatory instructions to Governors or Directors of contracted prisons are written in italics. Each PSO is given a title and unique reference number.

**Roll checks at night**

23. Roll checks by night staff are carried out at about 9.00pm by the night officer responsible for the area, when they first come on duty. In order to check the roll, the officer opens the cell door observation panel and looks into the cell. The officer is checking to confirm that the prisoner is in the cell and that the correct numbers of prisoners are accounted for. Unless there is a specific requirement to check a prisoner or prisoners, the next roll check is not carried out until about 6.00am the following morning.

**Assessment, Care in Custody and Teamwork (ACCT)**

24. ACCT monitoring requires staff to identify any concerns, take action, and document those actions for prisoners identified as at risk of suicide or self-harm. The ACCT document should be available to all staff where the prisoner is located. Within 24 hours of the document being opened, the prisoner will be seen by a trained ACCT assessor and have a case review meeting, which is a multi disciplinary meeting. The meeting draws up a care and management plan, known as a Caremap, and a member of staff is nominated as the case manager. Wing managers are specifically trained to take on the role of case manager, oversee the management of the ACCT document and attend case reviews.

**Listeners**

25. The prison has a “Listener Scheme”, which is a system where the Samaritans train selected prisoners to be the first contact for any prisoner who is feeling vulnerable or at risk. The scheme is confidential and any prisoner can request to speak to a Listener at any time of the day or night. Prisoners can access a Listener easily by speaking to a member of staff, who will then make the arrangements for a trained Listener to speak to the prisoner concerned. During the hours that prisoners are locked in their cells, anyone wishing to speak to a Listener can make the request from the staff on duty. At night, the Night Manager has the authority to unlock a Listener and to escort him to the cell of the prisoner who is requesting assistance. This investigation has not identified any occasion when the man asked to speak to a Listener.

**Care team**

26. Each prison has its own care team. Care team staff are drawn from all areas of the prison and trained specifically to help and support prison staff. Following any serious incident, they provide an invaluable role to any member of staff who requires support.

## Emergency response codes

27. In the event of urgent medical assistance being required, a number of prisons have chosen to adopt codes to alert medical staff to particular incidents. At Lewes the code is “Level 1 emergency”. This code tells medical staff that the patient is in a life threatening position. In prisons where codes are used, the healthcare departments have created emergency response bags which contain the necessary equipment to deal with the particular incident. This ensures that medical staff takes the correct emergency equipment with them and helps provide the necessary medical care as quickly as possible.

28. As well as the emergency response bag, the prison healthcare has placed a bag containing emergency equipment on each wing. Additionally, there are automatic defibrillators on each wing, making access to emergency equipment quick and efficient.

## Police investigations of deaths in custody

29. With all deaths in prison custody, the police are notified by the prison as soon as the death has been discovered. In the first instance, the police treat the area where the person is found as a potential crime scene and, as part of their investigation, note the names of everyone involved and those who have been in contact with the body. Additionally, they note the identity of all those entering and leaving the cordoned area. It is only when the police are satisfied that the death is not suspicious that the Ombudsman’s investigators are allowed to begin their work. In the man’s case, the police officer dealing with the death has confirmed there are no suspicious circumstances and given approval for the investigator to continue with his work.

## FINDINGS

30. The clinical reviewer has noted that the man had said during a mental health assessment that he had experienced symptoms of depression in the past. He said this was due the death of his father eight years earlier and his 17 year old son, who died as a result of a road traffic accident in 2004.

31. On 21 April 2009, the man appeared before a magistrates court charged with perverting the course of justice. The charge related to the disappearance and subsequent death of his daughter in 2008, in which the police suspected he was involved but he denied.

32. Whist at court, a mental health assessment was carried out by a Forensic Community Psychiatric Nurse, to determine whether the man was fit to enter a plea. The Nurse noted that the man was not known to local psychiatric services, but that there was historic evidence in the form of "markers" regarding suicide, but no information as to why the markers were there. The man also said that he had experienced psychological problems since 2004 after he became depressed following major heart surgery.

33. After a short appearance in court, the man was remanded into prison custody. He was taken to Lewes by staff employed by the private escort service, SERCO.

34. As part of the normal procedure for escorting prisoners, a Prisoner Escort Record (PER) was completed. (The PER form is designed to identify any known risks and record a small amount of information needed to aid the escort and prison staff.) In the man's case, two medical risks were identified. One related to the earlier heart by pass operation and the other to a diagnosis of depression. Additionally, there were risks identified relating to a history of violence and possession of weapons. Under the section "Other" which forms part of the PER form, the box "suicide/self harm" has been ticked. However, it is not clear what and when the event was.

35. In addition to the PER form, a suicide and self harm warning form was completed by a member of the security staff based at the magistrates court. On that form, the person completing it ticked one of the concern boxes to indicate that the man appeared depressed. It was also noted that he was receiving medication for depression and had said he had been on hunger strike for two weeks.

36. The man arrived at Lewes shortly after 3.30pm. When he arrived there, he was first taken to the reception department, where his details were recorded. After noting the man's details, a cell sharing risk assessment (CSRA) was completed. (The main purpose of the CSRA form is to assess whether there is a risk to another prisoner if required to share a cell.)

37. At section two of the CSRA, it was noted by the officer completing the document that the man had arrived at the prison with a self harm warning. In addition, at section three, it was noted that the man had thoughts about

harming himself whilst at court that day. The person completing the form added that the man was being treated for depression and supported by a bereavement councillor. As a result of these concerns, the man was admitted into healthcare for what was noted as “continued assessment of mental state”.

38. Due to the concerns noted on the CSRA form, an officer opened an ACCT document. The time of opening the document is recorded as 6.30pm. Under the heading of “Concern and keep safe form” the officer wrote the following:

> “Due to the loss of two children, one in mysterious circumstances, the man is feeling lost and vulnerable. States he will not kill himself due to his daughter and granddaughter needing him. Due to high profile case this document opened possibly precautionary.”

39. Having opened the document, the next stage was to complete the “Immediate action plan”. The ACCT document shows that the plan was completed by an SO and the officer and a member of the in-reach team were present. The SO placed a tick in box three and four of the plan. Box three notes “unusual behaviour”, whilst box four indicates “very low in mood”. The man was placed on frequent observation which, from the ACCT record, appears to have been about every two hours. As well as admitting the man into healthcare, he was advised how to access the Listeners. He was also given advice on how to contact the Samaritans.

40. At 7.00pm, the officer completed the assessment section of the ACCT document. The document was then passed to an ACCT case manager for completion. The clinical reviewer comments in her clinical review that the assessment of the man’s mental state recorded that he felt he was being punished by everyone, due to the death of two of his children. A referral was made to the prison mental health in reach team.

41. The following day, on 22 April at about 5.00pm, an ACCT case review meeting was held. The meeting was chaired by Registered Mental Health Nurse (RMN). Also there was another RMN and the man. In the case summary, the case manager wrote:

> “Very tearful during assessment. Reports being on hunger strike for last 2/52 [I understand this means two weeks]. Denies suicidal ideation, believes he is being punished by the police for interfering in the case. Has only eaten a few mouthfuls of food this evening and only sips of fluid.
>
> “To remain on open ACCT and refer to psychiatrist”.

42. After the case review was completed, the next action should have been to complete the Caremap. However, contrary to proper procedure, it would appear from the records that this was not done.

43. An RMN wrote a retrospective note in the man’s medical record. In that entry, the nurse said the man had been seen the previous night for a mental health

triage assessment. The nurse went on to say that he denied having any suicidal ideas or plans to harm himself.

44. Further entries made in the medical record describing the man as tearful, isolated, showing symptoms of neglect and only speaking when approached. It was noted that he showed signs of feeling "brighter" as a result of staff intervening and, on 25 April, it was noticeable that he had cleaned his cell, and that his mood appeared stable.

45. On 28 April at 10.20am, the second case review meeting was held. Once again, the case manager was an RMN. The record shows that another RMN was present, as well as the man. It also shows that, again, no Caremap was completed. In the case summary section, one of the RMNs wrote the following:

> "Mood more stable currently dealing with stress factors more appropriately.
>
> "No issues with eating and sleeping. Believes he needs to look after himself for his remaining children. No suicidal ideation or mental health issues."

46. Because of the improvement in the man's mood, it was agreed that he no longer needed to be in healthcare and that he could move to a normal cell within the prison. Before he did so, a mental health in reach assessment was completed and he moved to an ordinary cell the following day.

47. However, shortly after moving to the new cell, the man was found to be "acutely distressed" and had packed all of his belongings. He asked to be taken back to healthcare. When asked to elaborate on how he was feeling, he told the nurse that "his head was going to explode and that he felt unsafe". He returned to healthcare overnight but the following day felt able to return to an ordinary cell.

48. The next day, on 30 April, the first ACCT Caremap was completed. There is no explanation as to why it had not been completed earlier, or what prompted its completion at that time. The Caremap shows that the man was to keep in contact with his family, obtain support from healthcare, have an appointment to be interviewed by a member of the in-reach team and to clarify who could visit him.

49. On 6 May at 10.40am, a third case review meeting was held. On this occasion the review was chaired by an SO. The record shows that an officer was also at the review with the man. In the case summary, the SO noted that the man had no thoughts of self harm and would speak to staff if he felt unhappy. At that point the ACCT was closed and a post closure review arranged for one week later.

50. On 12 May, the man was charged with the murder of his daughter and further remanded into prison custody. His case was regarded as being high profile in the Sussex area and had attracted a great deal of media interest.

51. In the meantime, the man was seen by a member of the mental health team. Although there was no evidence of severe or enduring mental illness, it was noted that because of bereavement and signs of depression a referral was made to a bereavement counsellor. There were no plans for any further input from the mental health team.

52. At the post closure review, a decision was taken to reopen the ACCT document. The reason was because the man had shown signs of depression and because details of his case were being broadcast on television and the local newspapers. From the record it would appear that the man was in agreement with the decision to reopen the ACCT document. The level of observations was set at four observations during the day and four at night.

53. Seven days later, on 20 May at 2.00pm, an SO chaired a case review meeting. There were also two officers present, and the man. The summary records that the man was tearful. He is noted as saying he had never attempted or had any thought of harming himself, but on occasions wished he would not wake up. It is not clear from the ACCT document what the level of observation was, but it appears to have remained at the same level.

54. On 27 May at 6.20pm, another SO chaired the next ACCT case review. An officer and the man were present. The SO noted that his mood was low, but that he had no thoughts of suicide. Although it is not clear from the documentation, it would appear the level of observation was adjusted to two hourly intervals.

55. An entry in the man's medical record made on 28 May recorded that he was showing signs of depression and poor sleep. It was noted that he felt this way when reading newspapers reporting his case. The man was prescribed an antidepressant tablet to help him to sleep better.

56. The following month, on 4 June, a further case review meeting was held. The case manager on this occasion was an RMN. Also present were an officer and the man. The case manager noted that the man was still low in mood, but had no thoughts of suicide. He went on to note that the man was having difficulty sleeping and he had advised him to speak to a doctor.

57. On 11 June, the Prison Liaison Officer held a case review meeting. He was assisted by an officer and a PO with the man also attending. The SO noted that the man said he had "fleeting thoughts of suicide", but added the thought went away when he reflected on his family. It was also noted that bereavement counselling, which had been identified as being required for the man, had not taken place. It was agreed that the SO would follow it up.

58. Twelve days later, an SO chaired a case review meeting. Also present were an officer and the man. Like the previous case review, the SO noted that the

man was still waiting to hear about bereavement counselling. The man's mood was noted as being "up and down" and so the ACCT document remained open. It would appear that the level of observation was about every four hours.

59. On 30 June, an SO chaired a case review meeting. An officer and the man attended the meeting. It was noted in the case summary that the man was in a more positive frame of mind and was now attending bereavement counselling sessions.

60. The following month, on 10 July, an SO chaired a case review meeting. An officer and the man attended and after reviewing the case history, it was agreed that the ACCT monitoring could be ended.

61. Seven days later, the Prison Liaison Officer chaired the post closure review meeting. Also present were an officer and the man. Although he was not sleeping well, the man seemed to have a more positive outlook. It was agreed that the ACCT document could remain closed. This appears to be the final occasion when the man was monitored under ACCT. The man told the meeting that he was receiving bereavement counselling and was finding it helpful.

62. On 11 August, the man was prescribed a three day course of zopiclone to help him sleep. On 27 August, the man asked for his antidepressant medication to be changed to mirtazapine (a more sedative antidepressant). This was agreed and a prescription was approved for him to take the medication at night. Additionally, he told healthcare staff that his appetite was poor and said he was experiencing suicidal thoughts. However, it remains unclear as to what was done with that information or whether any consideration was given to opening another ACCT document.

63. On 15 October, the man complained to healthcare of chest pain and is reported to have said the pain was similar to that experienced before his heart operation. An electrocardiograph (a recording of electrical activity in the heart) was carried out, although it is not clear what the outcome was.

64. Twelve days later, the man saw healthcare again and said the prescription for mirtazapine was not helping him sleep. The entry in his medical record suggested that he was to be referred for a psychiatric assessment, but does not show whether the referral was made or not.

65. The following month, on 10 November, the man was seen in healthcare. It is not clear from the medical record who saw him, but it was recorded that the mirtazapine prescription was not helping. The man said he was sleeping during the day, but not at night. The person who saw the man has made an entry noting that he had a "very low defeated presentation". (Once again it is unclear what if anything was done with the information.) The man was also advised to keep a sleep diary to record how well he slept.

66. Two weeks later, on 25 November, the man was seen by a doctor to prepare a medical report for his court appearance. The doctor described the man as "suffering from mild to moderate depression with feelings of self harm but no plans". (To assist her clinical review, the doctor asked for a copy of the report but said "it was not possible for it to be released". She added that the psychiatrist for the man's defence team had written in his medical record. The clinical reviewer said that, although the man presented with mild to moderate depression, he was not actively suicidal when assessed.)

67. On what appears in the medical record to be 26 November, the man was seen by a doctor. The man had kept the sleep diary, but the remaining entries in the medical notes are indecipherable.

**January 2010**

68. On 1 January, as it was a Bank Holiday, prisoners were allowed out of their cells to associate with other prisoners. During association, prisoners relax, mix with other prisoners and move freely around the wing.

69. As part of this investigation, the investigator spoke to an officer, who had signed the landing roll as being correct at 5.15pm. The officer said he could not remember whether he had locked the man into his cell that evening. He said that although he signed the roll, other staff may have locked the cell. He might well have simply collated the landing roll and signed for it. However, he went on to say that he remembered seeing the man out of his cell during association that afternoon and described him as behaving normally. He also said the man had collected his evening meal shortly before being locked up for the night. The officer said that had the man, or any other prisoner, not collected their meals, the normal routine is for officers to go the prisoner's cell and check why they have not done so.

70. The officer also told the investigator that each evening prisoners are provided with "breakfast packs". This means that prisoners are not unlocked early to collect breakfast. They would not expect to be unlocked until it was time for either the weekend association period to start, or, during the weekday, begin work or education classes.

71. After the cells were locked at 5.15pm, the majority of the prison staff left for the day having completed their work. However, there were staff on each wing who remained pending the arrival of the night staff.

72. On duty that evening in Sussex Wing was an officer. He said that at about 7.15pm he carried out a roll check. He said he remembered seeing the man sitting on his bed watching television. The officer said when he looked into the cell, the man waved to acknowledge him.

73. At about 8.00pm, an Operational Support Grade (OSG) began his night patrol duty in Sussex Wing. He told the investigator that when he arrived he received a handover from an officer. The OSG said he was told about those

prisoners being monitored under ACCT and was not given any specific information relating to the man.

74. The OSG said that, shortly after taking over, he carried out a roll check. He said he looked into every cell through the door observation panel to confirm that all prisoners were accounted for. Although he did not recall the man, he said he would have seen him, as he had confirmed the roll as being correct. He went on to say that because the man was not being monitored there was no reason to see him again until the following morning roll check.

**2 January**

75. At about 5.30am, the OSG carried out the morning roll check on Sussex Wing. He said he looked into all cells to ensure prisoners were accounted for, adding that he is not required to obtain a response from the prisoner unless they are being monitored. The OSG said that when he looked into the man's cell it was dark, but he did remember seeing him lying face down on his bed. Content that the man was in his cell, the OSG carried on with the roll check and later confirmed the wing roll as being correct.

76. The investigator has examined the local instructions for night time roll checks. Local instruction 2.73 states that night time roll checks are conducted to ensure the roll is correct and that every prisoner is in the correct cell. Unlike that instruction, local instruction 2.79, which is specifically written for the purpose of night observation of prisoners an ACCT, it states that staff must note the following information in the ACCT document:

- The position of the prisoner.
- Whether they are awake or asleep.
- Any conversation that is made.
- If impossible to view the prisoner, every effort must be made to gain a response. If this is not possible, the Night Orderly Officer must be contacted.

77. During a meeting with the investigator, an officer said he arrived on Sussex Wing at about 7.00am on 2 January. The officer said his first duty that morning was to take over from the OSG so that he could leave the prison after completing his night shift. The officer told the investigator that before leaving the wing, the OSG had told him what the wing roll was and that it was correct. He said the OSG did not mention anything about the man.

78. Satisfied that the OSG had confirmed the roll as being correct, the officer carried out his own check of the prisoners being monitored under ACCT. He said the man was not being monitored and therefore he had no reason to look into his cell. The officer added that he is not required to carry out a further roll check, explaining that it had been completed by the OSG. The officer went on to say that at about 8.30am, the remainder of the shift arrived for work.

79. As it was a weekend, the wing routine was different to that during the week. Prisoners on Sussex Wing are not unlocked until about 10.30am when they

are free to mix with other prisoners and relax (usually referred to as association).

80. At about 10.15am, Sussex Wing was unlocked to allow prisoners to associate with each other. There was another officer responsible for unlocking the man's cell that morning. (Following the man's death, all the staff involved made written statements of what they had done. This is normal practice following any serious incident.) In his written statement to the Governor, the officer said that he looked into the man's cell through the observation panel and then opened the cell door. He said the cell was in darkness and, when he spoke to the man, "it appeared he turned his head to acknowledge". In his police statement written on 13 January, the officer said "As I shouted good morning, I thought I'd seen his head move in acknowledgement … although I cannot be sure". The officer then moved to the next cell and continued unlocking the remainder of the cells, after which he moved downstairs to an office to continue with other duties.

81. The investigator asked the officer how well he knew the man. The officer told him that the man had often spoken to him about his case, telling him he was innocent. The officer said that at no stage was he concerned for the man's safety. He went on to say that, with hindsight, he recalled the man being much quieter over the Christmas period than normal, but not to the extent that suggested that he was vulnerable or required monitoring under ACCT.

82. The investigator examined whether anyone had carried out a routine cell fabric check that day and, if so, at what time. (Fabric checks are carried out daily to ensure the cell is not damaged and that the in cell lights and emergency call button functions correctly.) The records show that it was an officer who signed to say the checks had been completed, although the record does not require a time to be inserted. He had been interviewed earlier, and the investigator decided to speak to him again. Along with an SO, the Prison Officers Association Secretary for Lewes, the investigator asked the officer if he could remember what time the fabric check was carried out on 2 January. The officer said he made the checks during the afternoon.

83. A remanded prisoner on Sussex Wing told the investigator that he had been in Lewes for about eight months and had known the man for about four months. He said they had become good friends and would often sit and talk to each other. The prisoner told the investigator that he had never had any concern for the man's safety. He said the relationships between prisoners and prison staff on Sussex Wing were good. The prisoner said that, if he had ever been concerned about another prisoner, he felt confident that he could speak to an officer and be taken seriously.

84. During the meeting, the prisoner said the man had, on two occasions, mentioned to him that he had been "looking at his razor blade" (meaning with a view to harming himself). He said the first time was in November and the next December. The prisoner said he did not take the man seriously as he had laughed when he said it. He went on to say that he was aware that the man had a number of issues on his mind, which he added was normal for

prisoners awaiting trial. One of the issues related to the charge of murder, which he said the man denied. Another was in connection to the custody of his children as he said police were investigating whether the man had committed incest and was the father of his own grandchild. That suggestion, the prisoner said, had upset the man and had occurred about one or two weeks before Christmas.

85. As part of this investigation, the investigator contacted the police officer in charge of the murder investigation, a Detective Chief Inspector (DCI). He told the investigator that the man's daughter had a baby girl and as part of the police investigation into the death of the man's daughter, they had carried bout DNA tests to ascertain who the father of the baby was. The DCI said police enquiries had included the man and those tests proved he was not the father of his grandchild. The DCI went on to say that the man would have known that the DNA test was negative, as it formed part of the police "disclosure papers" sent to his solicitor.

86. Over the Christmas period, the prisoner noticed a change in the man's behaviour. He told the investigator that, for the man, it was a low period in his life, because his case was due to be heard in court in the New Year. However, he did not feel the man was at risk and had no concerns for his safety.

87. At about 11.00am, the prisoner went to the man's cell and saw that the cell door was unlocked, but not open. He looked into the cell through the observation panel and, although the cell was dark, could see the man on the bed. The prisoner said the cell was dark because there was a curtain up against the window, but there was sufficient light to illuminate the cell, albeit dimly. He said the man was laying face down, naked on the bed, with his right arm hanging down to the floor. Believing he was asleep, the prisoner left the cell and went to speak to another prisoner on Sussex Wing.

88. The prisoner said that he and the other were laughing at the fact that the man was still asleep and naked. Between them they discussed whether someone should enter the cell and cover him up, as there were female officers on the wing and did not want him to get into any trouble for being incorrectly dressed. At that point they were undecided about what to do.

89. After a while, the prisoner returned to the man's cell with the intention of covering him up. He told the investigator that, rather than look into the cell through the observation panel, he opened the door. As he did so he saw the man and realised straight away that he was dead and so did not go inside. Instead, he went to the other prisoner's cell and told him what he had seen and asked for his assistance. He said they both then went to the man's cell.

90. The prisoner said that the other prisoner went into the cell and checked for a pulse but did not find one. At the same time, the prisoner asked an officer for his assistance. He said the officers responded quickly.

91. The investigator asked the prisoner if he could remember what he had seen and what the condition of the man's body was. He said the cell floor was smeared with blood and underneath the sink there were a number of bed covers with blood on them. He went on to say that the man's body looked grey in colour. He said he knew straight away that the man was dead.

92. At interview an officer said when he looked into the cell he saw a lot of blood and that the man was laying face down on the bed. He said he used his prison radio to request assistance and healthcare staff arrived quickly. The officer said he did not go into the cell, but from what he could see he suspected the man was dead.

93. Two officers went into the cell. One of the officers told the investigator that when he entered he saw the man laying face down on the bed. He said the man was naked and lying with his head towards the cell door, with his right arm hanging over the bed towards the floor. The officer said there was a large pool of blood on the floor underneath the window and on the mattress. He added there were blood stained blankets on the floor.

94. The officer said that he and the other officer turned the man over onto his back with the intention of performing cardio pulmonary resuscitation (CPR). He noticed a razor blade sticking into the man's chest and a number of cuts to his arms, along with dried blood. The officer said the body was "very cold and stiff". Just as they were going to begin CPR, a matron arrived and took over the man's care.

95. At interview, the matron said that she had been in an office in healthcare, along with a staff nurse and a nurse, when the radio call came through for medical assistance. She said that from the tone of the radio operator's voice, she knew it was serious. At that point, along with the staff nurse and the nurse, they set off to Sussex Wing. The staff nurse collected a grab bag containing emergency medical equipment and that both he and the nurse followed her to the Wing.

96. When the matron arrived, she was directed by staff cell 3/02. At interview, the matron said when she entered the cell she saw the man on the bed. She checked for signs of life but could not detect any. She added that the man's body was white, with signs that his blood had settled to its lowest point and, that he was cold to touch. The matron added that, in her opinion, the man had been dead for some time. She said his elbows were extremely stiff, which suggested to her that rigor mortis was evident.

97. The matron said because she and her staff are not permitted to pronounce death, she took the decision to commence CPR. In order to start CPR, assisted by other staff, she turned the man onto his back. As they rolled him onto his back, she saw two razor blades stuck to the man's chest. In addition to finding the razor blades, the matron saw two vertical cuts to his right wrist.

98. The staff nurse said he recalled noticing that the man had no pulse, and his skin was blue. His first thought was that the man had been dead for some

time. The nurse went on to say that he had difficulty in inserting an airway as the man's jaw was stiff, because rigor mortis was evident. The staff nurse said he saw cuts to the man's wrist and one to the brachial vein (a deep vein in the upper arm), which he described as being the more serious of the cuts. The matron also saw the cut to the brachial vein, but had not noticed it initially due to the man's arms being so stiff and curled upwards.

99. In the meantime, and as part of the normal procedure, an emergency ambulance had been called. At 11.35am the first of three paramedics arrived and he continued with CPR. Ten minutes later, another paramedic arrived and attached an automated defibrillator to the man's chest. The defibrillator did not detect any output from the man's heart, and so instructed them to continue with CPR.

100. At 11.50am a third paramedic arrived. The matron said the paramedic told them to stop CPR and at 11.52am he confirmed that the man had died. (I understand that the paramedic is qualified to confirm death.)

101. The investigator asked the matron why, when rigor mortis was present, she had instructed her staff to carry out CPR. She said that she and her staff are not qualified to say whether a patient has died and, until death is confirmed by a doctor or trained paramedic, CPR has to start and be maintained until they are told to stop by a suitably qualified person.

102. The matron said that, while her staff and paramedics were performing CPR, she had looked around the man's cell. She said she found a number of blood soaked towels on the floor covered over by a sheet. The matron's opinion was that the man had bled into the towels, covered them over and then lay down on his bed; to give anyone looking into the cell the impression he was asleep. She believed that the man's actions were well planned.

**Following the man's death**

103. The prisoner said prison staff took over and he was asked to return to his cell, which he did. He said he felt unsupported and that the only members of staff to ask how he was were was an SO and an officer. He added that following the man's death, prisoners on Sussex Wing had contributed towards a wreath.

104. Following the man's death all the prisoners being monitored under ACCT were reviewed, which is normal procedure. The purpose of doing this is to ensure there was no adverse reaction to the death.

105. Prison and healthcare staff said they had felt well supported by managers. Particular praise was given by them to the local care team for their help and continued support.

106. In addition to the care team, there was a 'hot debrief' chaired by a senior manager who met the staff involved. I understand the Governor has also arranged for a critical incident debrief to take place.

107. Due to the high profile nature of the man's case, the police took the decision to inform his family of the death. Having been told, the prison Family Liaison Officer kept in contact with his family and arranged for a wreath to be sent to his funeral. I understand the prison assisted with the cost of the funeral and that the man's son was allowed to visit the prison and the cell where his father had died.

## ISSUES

### Assessment, Care in Custody and Teamwork (ACCT)

108. Upon completion of an ACCT case review, the case manager is required to complete the CAREMAP section of the document. Written in bold letters on the action following assessment section, it states "Now produce CAREMAP and liaise with appropriate staff and support agencies. Note any known trigger/warning signs on the inside front cover". There is no evidence that the CAREMAP was completed on 22 April and it appears that the first one was not written until 30 April, a week after the ACCT support began.

109. Additionally, not all those who acted as case managers in the man's case had been trained to do so. (The investigator has confirmed this with an SO, the prison's suicide prevention co-ordinator.) This is contrary to the mandatory instructions contained in PSO 2700 which states "ACCT case managers must be minimum grade of senior officer or nurse band five and have successfully completed the training for ACCT case managers".

110. Following the man's death, the Offender Safety, Rights and Responsibilities (OSRR) team of the National Offender Management Service (NOMS) issued a "Quick time" learning bulletin to all staff. The bulletins are published by NOMS to help establishments identify potential safer custody risks and take remedial action where required.

111. I understand from NOMS that the bulletin was issued as a direct result of the man's death. It highlights the main issue as the need for extra vigilance for prisoners facing trial for specific offences or those which have attracted public interest. It goes on to say:

> "A recent apparently self inflicted death has highlighted the risk of self harm and suicide associated with trials that are likely to expose the prisoner to particularly intense emotional pressure."

The bulletin lists a number of circumstances likely to increase risk and includes the offence for which the man was in custody.

112. Although in its early days, I find the bulletin to be an informative document and I welcome its introduction. If it helps prevent another death, then it is a worthwhile initiative.

113. In their guidance, the OSRR team asks prisons to examine the processes they have in place to identify and support prisoners who are on, or have previously been on, an ACCT and have a key event such as trial or anniversary approaching. It asks that case reviews or post closure reviews are arranged with those events in mind and whether prisons have systems to accurately record and share information, particularly in relation to the nature of the offence and upcoming trial.

114. The guidance goes on to quote section 4.10.2 of PSO 2700 and reminds Governors that the section is a mandatory action. It states:

> "Establishments must make provision for additional risk assessments and care to keep safe prisoners who have been charged with domestic violence and /or domestic murder/murder of a family member. Such provision must include ensuring a record is maintained to show what action has been undertaken."

115. In the man's case, he had previously been on ACCT monitoring and his trial was imminent. It is also clear that the offence was high profile and had caused a great deal of local media interest. However, there is no record of his closed ACCT being reviewed, nor of the mandatory action quoted being actioned.

**The Governor should ensure that the mandatory actions contained within PSO 2700 are in place particularly in respect of prisoners charged with domestic violence.**

**The Governor should consider how best to ensure that whenever a trial date has been identified as a trigger factor for self harm, or where it might be identified that a high profile case may lead to concerns regarding a persons mental health, the courts, prison and healthcare liaise to ensure that appropriate care plans and risk assessments are in place.**

**The issuing of razor blades**

116. The man's son has asked why his father was allowed to keep razor blades in his possession. Unless a prisoner is deemed at immediate risk of harming himself by cutting, it is normal practice to allow them to keep razors in their possession. In the man's case he was not considered to be at risk and so there was no reason not to allow him to have a razor in his cell. Although he had harmed himself before, it was some months earlier and not by cutting himself. I am satisfied that there was no obvious reason why he should not have been allowed to keep razors in his cell. To have deprived him of equipment to keep himself shaved and tidy, would have reduced his independence and dignity.

**Resuscitation attempts**

117. Contained within PSO 2700 "Suicide prevention and self-harm management" at annex 13, under the sub section "hanging" is the following statement:

> "If not breathing and/or no pulse is present, clear airway and attempt resuscitation, using face mask with non return valve, unless rigor mortis has <u>clearly set in</u>…"

Under the heading resuscitation, the PSO says:

> “Policy remains that staff should continue to attempt resuscitation – as appropriate to the injury - until told to stop by a healthcare professional, e.g. a member of the ambulance service or a doctor or rigor mortis has clearly set in. Rigor mortis is a condition of extreme stiffness affecting the arms and legs after death, making it virtually impossible to bend the wrists, elbows or knees.”

118. However, local contingency plan number seven for Lewes, entitled “Death in custody” and updated as recent as January 2010, does not contain the same guidance. At section (f) it tells the reader to attempt resuscitation if the prisoner is not breathing.

119. Although working in a prison environment, the nursing staff are employed by East Sussex Community Health Services. Contained within their “Verification of expected death in the community/intermediate care units by registered nurses policy” it states in bold letters “if death is sudden or unexpected, it is the registered nurse’s duty to commence resuscitation procedures and call immediate emergency support and ambulance services”.

120. It is clear there is a conflict between what the NHS policy and local contingency plan says, when read alongside PSO 2700. This leads to confusion among the nursing staff.

121. It was obvious to the nurses, all of whom are experienced, that the man was dead and he had been so for some time. It was evident to them that rigor mortis was present and yet they felt they had no option other than to perform CPR, or risk disciplinary action from their employer.

122. I have considered the nurses’ actions and, given the confusing instructions and perceived possibility that they could be disciplined by their employer, it is hardly surprising they tried to resuscitate the man. That said, given the extremely difficult situation they were faced with, it is my opinion that they acted decently and humanely with the man. Their actions are a credit to the service they represent and are commendable.

**I invite the East Sussex Community Health Services to commend the nurses for their actions in attempting to resuscitate the man.**

**The Governor, in partnership with the East Sussex Community Health Services, should ensure that polices are clear as to when it is reasonable for any member of prison staff including healthcare staff in the prison environment, not to attempt resuscitation.**

## Clinical care

123. In her report summary, the clinical reviewer said that, when he arrived in custody concerns were raised about the man's mental state. She said he had told healthcare staff that he felt he was being punished by the police. He added that he had not had food or drink for two weeks before he was remanded and intended to continue his hunger strike. The clinical reviewer said he was admitted to the healthcare centre and remained there for one week, during which time she notes his mental state stabilised and he began to eat and drink appropriately.

124. The reviewer notes that after the ACCT was closed, the man continued to see the prison doctor, complaining of having difficulty sleeping. She said he had previously been prescribed antidepressant medication before arriving in custody, to assist him with his mental state. The medication had been changed to a sedative antidepressant, in the hope that it would assist him with his sleep difficulties. Prior to that in the community and, for a number of short periods during his imprisonment, he took zopiclone, which is a mild sleeping tablet.

125. The clinical reviewer notes that the man was referred to the prison mental health in-reach services and was assessed following his discharge from healthcare. She said it had been felt that he was experiencing depressive symptoms which had resulted from the criminal proceedings. Additionally, she notes that the man was believed to be suffering from a bereavement reaction and had been referred for counselling. The reviewer adds that there was a suggestion that his mental health difficulties could be managed by primary care practitioners.

126. The man was not, however, re-referred to the prison mental health in-reach team. However the clinical reviewer notes that handwritten entries in the medical record, which she believes were made by a doctor, suggests there had been some consideration of a re-referral but that this was not acted upon.

127. The clinical reviewer said the post mortem blood analysis showed that the man had taken antidepressant medication as prescribed and that there was no evidence of an overdose of medication. However, she said that the post mortem had discovered that there was a high level of blood alcohol which could not be explained.

<u>Record keeping</u>

128. In her report, the clinical reviewer said that on the whole the handwritten entries in the man's medical record were signed and dated, with the designation of the author identified. However, she said some of the entries were difficult to decipher and it had not been possible to be entirely sure who had completed entries and what designation they held. In particular some of the latter entries made by doctors were difficult to read, adding that it was not clear that where there was mention of a re-referral to the prison mental health in-reach team it had been actioned.

**The Head of Healthcare should ensure that medical entries are legible, dated and signed and the designation of the author identified. Any plan of action needs to be clearly defined, with an indication as to how actions will be progressed and by whom, if they are not to be completed by the author.**

Reception medical screening

129. The clinical reviewer said that there were only partial copies of the reception medical screening documents within the man's medical record. The reviewer went on to say that the first night assessment procedures appear to have identified from information coming into the prison that the man had presented a risk of self harm previously. However, she stresses they had not identified how this had been established and it appears that this question was not asked.

**The Governor and Head of Healthcare should ensure that, when a prisoner arrives at prison with information about previous risk of self harm, it is important during the reception medical screening that they are asked about the nature of this past risk, and its context.**

Mental Health

130. The clinical review notes that the man did not appear to have had any significant mental health history. However, the reviewer has said that, at the time of his reception into custody, he was prescribed antidepressant medication by his general practitioner. The man had said that he had mental health difficulties since 2004, following a heart bypass operation.

131. The clinical reviewer said it appears from the man's medical record that there no attempts were made by healthcare to verify the information by obtaining his medical records from his own doctor. She said that when he arrived into the prison, after being admitted into healthcare, the man was referred to the prison in-reach mental health team for assessment. The doctor said the assessment took place and it would appear from his medical record that he was not accepted for treatment by the in-reach team, but was instead returned to primary care for continuing treatment. She adds that the decision was not understood by the primary care team. The reviewer went on to say she noted that on two occasions towards the end of 2009 there had been a suggestion that the man should be reviewed again by the in-reach team. However, there is no evidence that the referral was ever made.

**The Head of Healthcare should ensure that there is a very clear method of informing those managing a prisoner whether or not they have been accepted by the in-reach team. In the event that a prisoner is assessed as not requiring in-reach services, a formal reply should be made to the primary care services to make them aware, with instructions about how they can re-refer should this be required later.**

**The Head of Healthcare should ensure that the members of the primary care team are clear that when a referral is considered, details of how the referral is actioned and by who are recorded in order to ensure that it occurs.**

**The Head of Healthcare should ensure that, whenever a prisoner presents with symptoms of low mood and suicidal thoughts, there should be a full examination of those symptoms and consideration given to referring to secondary mental health in-reach services, as well as opening an ACCT if appropriate.**

Communication

132. Referring to a letter contained in the man's medical record, the clinical reviewer said he had written to the PCT as he felt his views regarding his night sedation medication were not considered. The doctor said his medication was changed to a sedative antidepressant medication, which she adds, was an appropriate response. The reviewer went on to say that despite this the man continued to attend healthcare with sleep difficulties. She adds that, although he was advised to undertake a sleep diary, it is unclear what the outcome of that intervention was.

133. The doctor went on to say that sleep problems are frequently raised by prisoners and it is widely recognised that medication is not the sole solution to the problem. She suggests that a sleep hygiene care plan makes it easier to support prisoners and for them to share the responsibility for addressing the problem.

**The Head of Healthcare should consider developing a sleep care plan that can be shared with prisoners and those who support them on the wings.**

Equitable care

134. The clinical reviewer said when the man was being supported in the community it was by a primary care team and that there had been no suggestion that he should be referred to a secondary mental health care team. The doctor adds that when the man was admitted into prison he was referred to secondary mental health care services and assessed, after which he returned under the care of primary health care treatment with advice.

135. The clinical reviewer went on to say that following his remand into prison, the man had received bereavement counselling, although there was a delay in it starting. She adds that delays also occur in the community but assistance may be quicker than in a custodial setting. The reviewer notes that the man had not accessed such counselling in the community.

## CONCLUSION

136. This case has highlighted the need to ensure prisoners charged with serious offences against members of their family and attracting local or national media coverage are assessed around the time of court hearings. I am pleased to learn that the NOMS issued a bulletin reminding prisons of the need for extra vigilance as a direct result of this death.

137. The man was monitored for a while under ACCT. I am satisfied that the support systems were in place for him and that he played a part in the process. It is clear that he was aware of what was available for him, but sadly he chose not share his final thoughts with anyone.

138. Whether the apparent suggestion that the man had committed incest played any part in his decision is not known, but it has to be a possibility. I am satisfied that he gave no indication about what he was going to do.

139. I have been disturbed to learn of the efforts made by nurses to resuscitate the man. It was clear to everyone that he was dead and had been for a long time. Despite this, nursing staff felt there was no other option but to carry out CPR. Clearly the prison and nursing instructions conflict and, for the sake of decency and dignity, I urge a solution and proper guidance be found quickly.

## RECOMMENDATIONS

1. The Governor should ensure that the mandatory actions contained within PSO 2700 are in place, particularly in respect of prisoners charged with domestic violence.

Accepted – “First Night interview procedure will be reviewed and updated to ensure that all prisoners have such enquires made against them. Each occasion where Domestic violence is noted, the First Night Centre (FNC) will ensure that the Safer Custody team are informed with the requirement being to link points 1 & 2 in this action plan and actioned accordingly. See 2 below. Records to be maintained by both FNC and Safer custody.”

2. The Governor should consider how best to ensure that whenever a trial date has been identified as a trigger factor for self harm, or where it might be identified that a high profile case may lead to concerns regarding a persons mental health, the courts, prison and healthcare liaise to ensure that appropriate care plans and risk assessments are in place.

Accepted: - The Safer Custody team have taken action in this area. They now identify prisoners who maybe high profile and for whom a trigger may be trail date, anniversary etc.
All prisoners considered/ identified and or potentially a high, including increasing risk, are current identified by the Safer Custody team and monitored. The Safer Custody Continuous improvement plan (CIP) will be updated to ensure mechanisms are in place and will evolve to minimise the risks. “

3. I invite the East Sussex Community Health Services to commend the nurses for their actions in attempting to resuscitate the man.

Accepted – “The Acting Head of Healthcare will be meeting with staff involved regarding this and will also write to them formally.”

4. The Governor, in partnership with the East Sussex Community Health Services, should ensure that polices are clear as to when it is reasonable for any member of prison staff including healthcare staff in the prison environment, not to attempt resuscitation.

Accepted – “The Acting Head of Healthcare is currently addressing this with PCT policy makers, with a view to bringing PSO guidance and PCT policy into alignment. Once policy is agreed within the PCT, the Head of Residence, The Head of HCC and the Head of Security will meet to update and reflect these changes in local contingency plans for both departments.”

5. The Head of Healthcare should ensure that medical entries are legible, dated and signed and the designation of the author identified. Any plan of action needs to be clearly defined, with an indication as to how actions will be progressed and by whom, if they are not to be completed by the author.

Accepted – “All clinical entries are now made into an electronic system. Each entry is automatically timed and dated and identified to each clinician via a unique log in. The functionality of the system allows the entry author to send a task to the clinician responsible for carrying out the intended action(s). “

6. The Governor and Head of Healthcare should ensure that, when a prisoner arrives at prison with information about previous risk of self harm, it is important during the reception medical screening that they are asked about the nature of this past risk, and its context.

Accepted – “The electronic reception template guides staff to enquire about the prisoners self harm history and to record this in detail.”

7. The Head of Healthcare should ensure that there is a very clear method of informing those managing a prisoner whether or not they have been accepted by the in-reach team. In the event that a prisoner is assessed as not requiring in-reach services, a formal reply should be made to the primary care services to make them aware, with instructions about how they can re-refer should this be required later.

Accepted – “All referrals to the Mental Health In-Reach Team are now reviewed by our substantive consultant psychiatrist. The referrer is notified formally of the outcome and invited to re-refer should the need arise.”

8. The Head of Healthcare should ensure that the members of the primary care team are clear that when a referral is considered, details of how the referral is actioned and by who are recorded in order to ensure that it occurs.

Accepted – “This detail is recorded on the electronic system.”

9. The Head of Healthcare should ensure that, whenever a prisoner presents with symptoms of low mood and suicidal thoughts, there should be a full examination of those symptoms and consideration given to referring to secondary mental health in-reach services, as well as opening an ACCT if appropriate.

Accepted – “All such cases seen in primary care by GP’s are assessed using an evidence based measure (PHQ-9). The results of this assist the GP in the decision of if a referral on to In-Reach services is required.”

10. The Head of Healthcare should consider developing a sleep care plan that can be shared with prisoners and those who support them on the wings.

Accepted – “A self help guide with workbook is available for prisoners with sleep problems.”