Circumstances surrounding the death of a man

at HM Prison Blakenhurst on 31 March 2006

Report by the Prisons and Probation Ombudsman
for England and Wales

February 2007

This is the report of an investigation into the death of a man at HMP Blakenhurst on 31 March 2006. At 4.15pm that day, he was found hanging in his cell.

The investigation was carried out by my colleague. I also commissioned an independent review of the management of the man's healthcare needs. This was conducted by a representative of the Redditch and Bromsgrove Primary Care Trust. I am grateful to the PCT for their work.

I should also like to thank the Governor and staff at Blakenhurst for their assistance and co-operation during the investigation. I am especially grateful to the Senior Officer at Blakenhurst who delivered a quality service as the investigation liaison officer.

Since the beginning of 2003, nine prisoners including this man have taken their own lives at Blakenhurst. This man's is the third self inflicted death that I have investigated there to date.

My report finds that the suicide prevention measures in place at Blakenhurst were, for the most part, satisfactory but that systemic improvements are necessary in some key areas, most especially in the healthcare centre. The investigation has also identified examples of good practice. I hope that Redditch and Bromsgrove Primary Care Trust, in partnership with Blakenhurst, will see the identified systems failures as a learning opportunity towards quality improvements.

I hope that the implementation of the recommendations I have made in this report will assist Blakenhurst to prevent yet another tragedy happening there in the future.

Stephen Shaw CBE
Prisons and Probation Ombudsman **February 2007**

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Summary

The man was arrested on 12 February 2006 and charged with a number of offences. He appeared in court the following day and was remanded in custody at Blakenhurst. Prior to his arrest, the man had been living in a property which he co-owned with a woman with whom he was living. The woman discovered his alleged offences and reported him to the police.

A member of the National Probation Service faxed a letter to Blakenhurst immediately after the man was remanded in custody, highlighting her concern that he was likely to present a risk of self-harm or suicide. The Probation Officer also drew attention to the man's potential vulnerability in prison, given the nature of the offences of which he had been accused.

The nurse who carried out an initial reception health screen on the man decided to open an ACCT (Assessment, Care in Custody and Teamwork) form so that his risk of self harm could be monitored. The form remained open until 2 March.

Although no secondary health screen was carried out, the man was referred for mental health assessment. An appointment for this assessment was scheduled to take place on 28 March, some six weeks after he was received at Blakenhurst, but was cancelled because of staff sickness.

The man was also referred to a Wellman clinic, because he was a diabetic and because he was over 50. The investigation found no evidence to show that he attended this clinic.

The man was given vulnerable prisoner status. As such he would normally have been located in Blakenhurst's vulnerable prisoner unit (VPU) but as there were no vacancies there at the time, he was held in the segregation unit on his first night. Thereafter, he was located in the VPU until his death on 31 March.

On 27 February, the man started education classes which he attended sporadically until 28 March when he was dismissed for playing snooker instead of being in class.

On 2 March, the self harm monitoring procedures that had been invoked on the day of his reception were terminated. On 9 March, a post ACCT closure interview took place. With the benefit of hindsight, I judge that the man's admission he spent most of his time in his cell was not given sufficient weight at the post closure interview. Thereafter, no further monitoring of the man took place.

On 28 March, the man was committed for trial and, as noted, was dismissed from his education class. He also received a distressing letter from his house partner.

On 30 March, the man drafted a letter to his solicitor about the contents of his partner's correspondence. It is clear that he intended to send this draft to his brother. However, none of this correspondence left his cell. The tone of his draft letters makes clear that he was deeply distressed. However, as he did not make staff aware of his feelings about these developments, they had no reason to intervene.

The man's cellmate noticed nothing out of the ordinary about him during the morning of 31 March or over the lunch period when they were locked in their cell together for the last time. However, at about 4:15pm, when the cellmate was still elsewhere, the man was found hanging in his cell by two members of staff.

I conclude that the suicide prevention measures in place at Blakenhurst prior to, and at the time of, the man's death, were for the most part satisfactory. However, I draw attention to the fact that no secondary health screen was carried out on the man after his initial reception at Blakenhurst. I record my concern about the cancellation of a mental health assessment for him six weeks after his reception. I suggest that the post-ACCT closure interview that was held on 9 March should not have been his last such interview. As with so many other cases, I also criticise the standard of record keeping.

The clinical review criticises a number of matters, including the management of the man's anti-depressant medication.

I also draw attention to examples of good practice.

I make a number of recommendations.

Investigation process

The investigation was opened on Friday 7 April when one of my assistant ombudsmen met with representatives of the Governor of Blakenhurst to brief them on the nature and scope of the investigation. On the same day, notices were issued to staff and to prisoners announcing the investigation and inviting anyone with information relating to the man's death to make themselves known to my investigators.

The investigation was carried out by one of my senior investigators. During the course of the investigation, one of my Family Liaison Officers telephoned the man's brother to ascertain whether he wished to express any concerns about the man's treatment at Blakenhurst and about his death. Although the brother did not wish to be visited, he nevertheless raised a number of issues. These have been addressed in this report.

I also commissioned an independent clinical review of the management of the man's health needs while he was in custody at Blakenhurst. This was conducted by a representative of the Redditch and Bromsgrove Primary Care Trust.

A number of staff were interviewed during the course of the investigation. Where it was possible to do so, those staff who were involved in the discovery of the man hanging and in attempts to revive him were interviewed jointly by my investigator and the clinical reviewer. A prisoner with whom the man shared a cell in the month before his death was also interviewed.

THE DECEASED MAN

The man was born in April 1947. He grew up in his parents' home with his younger brother and his two older sisters. He was particularly close to his brother. His father died in 1981 and his mother in 1992.

The man was shy as a child and therefore gained few friends. He was occasionally bullied during his primary school years. He left school after taking his exams and was soon employed as a junior clerk for a firm of solicitors, a job he held for nearly five years. He was next employed as a junior conveyancer until the age of 29. This job came to an end when he became ill and spent a period of six months as a psychiatric inpatient. In May 1978, he left Derby and took on another job as a junior conveyancer. Despite becoming ill again, the man remained in this employment for 25 years before finally retiring.

At the time of his arrest, the man co-owned a house with a woman who discovered and reported his alleged offences.

The man was a just a few days short of his 59th birthday when he died.

HM Prison Blakenhurst

HMP Blakenhurst is located on the outskirts of Redditch in Worcestershire. It is a category B local prison, serving a number of courts in the West Midlands.

It opened in 1993, and, until Spring 2001, was operated by a private contractor, United Kingdom Detention Services (UKDS). Later that year, following a "market testing" exercise, the responsibility for the management of the establishment was returned to the Prison Service. At the time of this investigation, Blakenhurst was managed under a Service Level Agreement, against which performance is closely watched by a Monitor appointed by the Home Office. The prison holds just over 1,000 prisoners in five houseblocks.

Healthcare is provided by the Redditch and Bromsgrove Primary Care Trust. The centre provides 24 hour nursing and medical cover and comprises two units: the primary care unit, situated on the upper floor, known as "upper medical", and an inpatient unit on the ground floor, known as "lower medical". There are 21 beds available in this unit. The primary care function includes the health screening of newly received prisoners, daily treatments and clinics.

The establishment last underwent a full unannounced inspection by Her Majesty's Chief Inspector of Prisons in December 2005. At paragraph 3.19 of her report of that inspection, the Chief Inspector wrote:

> "Safer custody has been given a high level of attention following seven self inflicted deaths at the prison between the start of 2003 and July 2004. There has been no self inflicted deaths since then [i.e. between July 2004 and December 2005]. Recommendations from the investigations into the deaths in custody had been developed into an action plan which has largely been implemented."

To date, two more prisoners, including this man, have taken their own lives since that inspection.

Key events prior to 31 March 2006

- *Arrest*

The man was arrested on 12 February 2006 and charged with a number of offences. That day, he was seen by a doctor in the police station. The doctor confirmed that he was fit to be detained and interviewed.

- *Appearance in court and remand into custody*

On 13 February, the man appeared in court and was remanded in custody to Blakenhurst. He was to ordered to appear in court again a week later. He arrived at Blakenhurst at 6.15pm. The Prisoner Escort Record (PER) for the journey noted that there was no known risk of self-harm. This was his first time in prison.

- *Reception at Blakenhurst*

During the reception procedures at Blakenhurst, an initial health screen was carried out on the man by a Registered Mental Nurse. He told the nurse that the only concern he had about his health was that he could not sleep well and that he suffered from arthritis in his knees and shoulder. He said that he did not take drugs or alcohol but had suffered from anxiety and depression. He told the nurse that he had been an inpatient at a psychiatric hospital in 1992 and that he had been prescribed MAOIs (Monamine oxydase inhibitors – anti-depressant drugs) in the past and was currently taking venlafaxine. He admitted that, when he was 29, he took an overdose of drugs and that, in 1992, he considered taking a further overdose but did not proceed. It was later noted that he was a diabetic.

Although the man explained that he did not feel like harming himself now that he was in prison, the nurse decided that he should immediately be subject to self-harm monitoring procedures. She therefore opened an ACCT (Assessment, Care in Custody and Teamwork) form. The nurse also referred him to the Wellman clinic. She told my investigator that anyone over the age of 50 was routinely referred to this clinic but that the man, who was 58 at the time, was also referred because he had diabetes.

The nurse made a record of her consultation with the man in his medical record against the date of 13 February:

> "Seen in reception. Referred to doctor mane [i.e. in the morning] for physical conditions and medication issues. Denies any intent to self-harm or suicide and no attempts to such for many years. However, ACCT form opened in reception in response to concerns raised by Probation Officer.

> Referred for mental health assessment and to Wellman Clinic."

The entry appeared in the record after another entry made by a doctor who saw the man the next day: Although no-one in the Healthcare Centre could indicate with any confidence which doctor made the entry, the generally held view was that it was made by a locum GP who no longer works at Blakenhurst. The entry records some details of the man's physical health and includes a comment that he had been an inpatient in a psychiatric hospital on three occasions.

It is not clear why this and the previous entry were not made in chronological order.

The Probation Officer to whom the nurse referred was the man's Probation Supervisor at the time of his initial court appearance. She wrote as follows in a letter to the reception manager at Blakenhurst on 13 February:

> "This will be the man's first experience of the custodial environment and I therefore feel it is necessary to consider him as posing a risk of self-harm or suicide. He currently experiences depression and I understand he has back problem and diabetes.
>
> I also have concerns about his being vulnerable. His thinking, appearance, communication and interpersonal skills are unique to him. He would thus stand out from others who may bully or intimidate him. I do not believe that he is prepared for some time in custody."

The man's medical record contains a blank secondary health screen form. My investigator was told that secondary screens no longer took place in reception at Blakenhurst. Instead, they were normally carried out in Houseblock 6 as part of the induction routine. As the man was not allocated to that Houseblock, no secondary health screen took place.

At interview, the nurse explained that there were two types of mental health referral: one was for those prisoners whose mental state was such that they needed to be seen by a Community Psychiatric Nurse (CPN) from the Mental Health In-reach Team, and the other was for less serious cases that could be managed by a Registered Mental Nurse (RMN) within the establishment's healthcare team. The nurse could not recall precisely whether or how the man's referral was followed up.

A Senior Officer signed the first page of the ACCT that was opened in reception on 13 February. He recorded that the reason for opening the form was that the man was at risk of self-harm or suicide because he was in prison for the first time.

- *Cell sharing risk assessment and first unit allocation*

A cell sharing risk assessment was carried out on 13 February by an officer. During the assessment, the man said that he had no concerns about sharing a cell and that he did not consider himself to be a person who became easily angry or frustrated. His risk of harming others was therefore assessed as low. The assessment concluded that it was safe for him to share a cell.

During the reception procedures, the man formally applied to be segregated from other prisoners because of the nature of his alleged offences. His request was immediately granted. My investigator was told that the man would normally have been placed straightaway in HB5 (houseblock 5), the prison's Vulnerable Prisoner Unit. However, that day there were no vacancies in that unit. The man was therefore placed temporarily in the Segregation Unit to await a vacancy in HB5. He was transferred to HB5 the next day.

- *ACCT assessment and caremap*

At 5:30pm on 14 February, a Senior Officer carried out an ACCT assessment interview with the man. The Senior Officer noted that he said he was not distressed but was suffering from depression that he had experienced for the last 30 years. The man explained that he was close to his family but did not see them frequently. He said that his family were supportive of him but were not aware that he was in prison. Neither did they know of the charges that had been brought against him. The man did not know how his family would cope if they found out. He told the Senior Officer that he did not feel suicidal but had not taken his medication for 36 hours and that this was the reason behind his current low mood.

The ACCT caremap was as follows:

Issues	Goals	Action required	By whom and when	Status of action
Not taken meds since 13/2/06	To take relevant medication	To see Doctor and access medication	Appt at 16:30 in HCC	Medication on order will be in medical 15/2/06
To inform family of arrival in prison and his charge	To gain family support	To liaise with family by phone/mail	Mr McArthur to give paper and arrange phone call if req.	Issued with phone call to family on 14/2/06. Further contact made by letter.
Needs to be seen by Doctor ref problems with sleeping and back pain	To receive any relevant medication	Doctor's application for appointment	Submitted 17/2/06.	Now on medication. 23/2/06.
Interaction with other prisoners/ constructive use of time	Commence education. Talk and converse with other prisoners.	To start Monday 20/2/06. Pad mate changed 17/2/06	- Completed.	Taken place 17/2/06.

The caremap makes no mention of the need to follow up the mental health referral made by the nurse the previous day.

The man's ACCT case manager that day conducted an initial case review in the Segregation Unit on 14 February, following the completion of the ACCT assessment interview. The case manager summarised the review as follows:

> "Is sharing a house with a woman outside, although it is an arrangement to get on the property ladder. Is feeling a bit sorry for himself at the moment but no immediate thoughts of self-harm. As a precaution, will leave open for 48 hours as he is moving to normal location. Observations: 1 entry per shift am, pm and evening. 2 hourly at night."

The case manager concluded that the current likelihood of further risk behaviours was low.

- *First ACCT case review*

The man's first ACCT case review took place on 14 February. The time at which the review took place was not recorded in the case review record. The review was attended by a Senior Officer in the role of case manager, another Senior Officer and the man himself. The review was summarised as follows:

> "Robert has been very open about his offence but is very down and quite withdrawn. He has to see the doctor at 16:30hrs today about his medication. Also has asked for a phone call which will be given tonight."

The box marked "caremap updated" was ticked. The next case review was to take place on 17 February. Two specific members of staff were to be invited to attend that review. The case review record does not indicate any change in the frequency of observations to be made. Neither does it show whether the man's risk was considered to have changed, nor whether any of the problems previously identified were reviewed (other than on the caremap).

- *Second ACCT case review*

The next case review took place as planned on 17 February. The review record shows that neither of the two members of staff invited to the review actually attended. At interview, one of them told my investigator that he was unaware that a recommendation had been made for him to attend. Those who were in attendance included a Senior Officer, a wing officer, and the man.

The review was summarised as follows:

> "The man is now in receipt of his prescribed medication. He has made contact by telephone with his family and is hoping his brother will help sort out his car and finances.

> To aid with the man not having had much conversation with his initial cell mate he now has a different cell mate of a similar age group. Says he feels that being able to talk but still feels he is somewhat overwhelmed by being in prison and events that have happened. Next court date 21/2/06. Review after that. Still preoccupied by his alleged offence and concerned over relationship with his ex partner. Observations to remain as set."

My investigator was told that the "ex partner" to whom reference was made in the review summary was the person with whom the man shared and co-owned his house.

The man's risk of suicide or self-harm was assessed as low. The box marked "Problems identified reviewed" was ticked as "yes" and the box marked "frequency of observations, conversations and recording requirements reviewed" was ticked as "no". In fact, the record shows that these issues were reviewed.

The next review was scheduled for 22 February. In fact, this case review took place on 23 February.

- *Concerns about the man's state of mind*

On 19 February, the following entry was made in the man's medical record:

> "Spoken to staff on houseblock. They are concerned about the man. – not sleeping, slightly anxious. RMN referral made – in court Tuesday 21/2/06 – to discuss i/c doctor x 2-3 days sleeping tablets – once he returns from court – to see the doctor on Wednesday 23 /2/06 – to discuss depression – and anxiety problem. "

The signature of the person who made this entry is illegible.

On the same day, the following further entry was made by a nurse:

> "Seen on HB5 after pill parade at officer request. Spoke to the man briefly. His main concerns seem to be with practical issues such as bill paying etc. It appears his medication requires reviewing as he was on venlafaxine at home and this is not currently prescribed. Complains of poor sleep. To be reviewed by MO re: short term sleeping tablets. Presents as poor coper who wants others to sort out his problems. Mood does seem low. 1st time in prison. Has court videolink on Tuesday. Had depression in Holymoor 1992. Would benefit from superficial level of support from RMN. Referral in place. ACCT already open."

- *Mental health referral*

As a result of her consultation with the man on 19 February, the nurse completed a mental health referral form on 21 February for him to be seen by a Registered Mental Nurse.

- *Court appearance by video link*

On 21 February, the man made a video link court appearance after which the following entry was made by an officer in the staff observation book:

> "Brought the man back from video link in very low mood. See notes in ACCT for more information."

The notes in the ACCT form to which the officer referred read as follows:

> "Whilst waiting for video link staff noticed prisoner had blood on both ears possibly due to scratching his ears constantly. His mood is very low and concerns about his mental state. Officer in legal visits has contacted the houseblock about concerns as he knows him from previous week in the prison. In court he was remanded in custody (No bail application possible as nowhere to stay). Staff need to monitor this prisoner closely for obvious reasons and interact on a very regular basis."

Subsequent entries made in the ACCT ongoing record show that, as the day progressed, the man became more cheerful and positive. During the following night he was observed every hour and no concerns were raised by staff. At 9:30 the next morning, the prisoner who shared the cell reported to staff that the man was in much better spirits.

- *Third ACCT case review*

At 3:45pm on 23 February, a third ACCT case review was conducted. This was attended by a Senior Officer, an officer and the man. The case review was summarised as follows:

> "The man is still taking prescribed medications. States he has no thoughts of self-harm. He got turned down on application for bail on 21/2/06 at court. He is due to start working, education on Monday 27/2/06. Remain open for time being and review in 7 days, when settled into education."

The man's risk of self-harm was assessed as low. The next case review was scheduled for 2 March.

- *Further concerns about the man's state of mind*

On 27 February, the following entry was made in the man's medical record:

> "Feeling really low in mood. Seen in nurse triage. Events happening outside prison are contributing to this deterioration in mood. Complains of increased ? flatulence due to stress. States co-dyd....BD is not adequate pain control."

The signature of the person who made this entry is illegible.

On the same day, a further entry was made by a doctor:

> "Try tramadol [an analgesic]. Not seen."

- *Engagement with education classes*

On 27 February, an Adult Learning Tutor persuaded the man to take part in education classes in the wing. At interview, the tutor explained that he realised the man's educational needs had not been assessed by that time, and so he decided to recruit him for classes. He told my investigator that an afternoon session took place each day in houseblock 5 for the vulnerable prisoners. The curriculum included art, computer skills and other subjects. According to the tutor, the man was clearly very anxious at the time he joined the classes but, although he did not appear to be suicidal, he appeared preoccupied and talked a lot about experiencing frequent panic attacks. The man pursued his education classes sporadically until 28 March, when he was removed for failing to attend.

- *Fourth and final ACCT case review*

At 9am on 2 March, a fourth and final ACCT case review was conducted. This was attended by a Senior Officer in the role of case manager, a wing officer, and the man himself. The review was summarised as follows:

> "The man is a lot more settled now. States he has no thoughts of self-harm. Fully aware of support network available. ACCT to be closed."

The ACCT document itself contains guidance to staff about conducting a post-closure interview. It requires that staff should conduct at least one such interview at an appropriate interval after the closure of the ACCT form. My investigator was told that, at Blakenhurst, post closure interviews are planned and managed centrally by the establishment's Safer Custody Team. This was to ensure consistency and quality control of post closure practice. A post closure interview of the man took place on 9 March.

My investigators examined in detail the record of observations made by staff in the ACCT document. Regular observations were made of the man throughout the period during which the ACCT form was open. Most entries are clearly legible and contain information that show an appropriate degree of staff interaction with the man. It is clear from those observations that there were

times when he appeared outwardly to be coping with imprisonment, but that there were also times when he was depressed. When it was necessary to do so, staff made appropriate interventions in order to ensure that he was supported.

It is also clear that the man drew significant support from his cellmates, to whom he would talk about his personal problems. My investigator interviewed his cellmate during the three weeks that preceded his death. The cellmate told my investigator that the man often demonstrated a degree of tension and anxiety when talking about his predicament. He often witnessed the man clutching his head and questioning whether he could continue to cope with the pressures he felt he was under. Those pressures, according to the cellmate, were more to do with events that were occurring outside prison than with the fact of the man's imprisonment.

- *Concerns expressed by a chaplain*

On 6 March, an officer made the following entry in the wing staff observation book:

> "Information received that while talking to [another prisoner], he told him that he was told how to kill himself such as putting his foot in water and putting an electrical item in the water…"

Underneath this entry, on the same date, the same officer wrote:

> "Reference earlier entry, the member of staff does not wish to open an ACCT form on the man."

The officer also wrote:

> "Spoken to the man and he has stated to me and the member of staff that he has no intention of self-harm."

At interview, the officer said that during the morning, a member of the prison's chaplaincy team came into Houseblock 5 to see the man and another prisoner. The officer said that the chaplain thought that the man was very depressed and "was not making a lot of sense". The chaplain advised the unit staff to open an ACCT form. The officer said he told the chaplain that, if he had any concerns about the man, he should open an ACCT form himself. The chaplain said he was about to see another prisoner and would see the man again if he had time.

However, the officer, who knew that the man had earlier been subject to self-harm monitoring procedures, was sufficiently concerned at what the chaplain had told him that he decided to see the man himself. He and another member of staff went to the man's cell. The officer spoke at length to him and asked him if he had any concerns or problems. He told the officer that he was concerned about his house, but that he was "over the worst of it". The officer

used his humour to cheer the man up and managed to make him laugh. In the other officer's presence, the officer asked the man if he felt suicidal. The man repeated that he felt he was "over the worst of it". He said that if he needed any help, he would go and see staff. The officers agreed that it was not necessary to open an ACCT form.

My investigator was told that the chaplain came back to the unit office a little later to confirm that he had seen the he man again and that he agreed that it was not necessary to open an ACCT form.

- *Post ACCT closure interview*

A post closure interview with the man took place on 9 March.

The review record comprises two A4 size forms, the first of which takes the form of a tick-box questionnaire for completion by the member of staff conducting the review. The second contains three boxes in which the prisoner's responses to the following three questions are recorded:

- How do you feel since the ACCT form was closed?
- Are there any outstanding or new issues/problems?
- What are your plans for the future?

The man's responses were that he had no intention of harming himself, that he had no outstanding problems and that he planned to sell his house and to gain funds so that he could move back to Derby on release. The interviewer noted at the end of the form, "Start doing some education. Brother is very supportive."

The questionnaire on the first page of the record showed that the reason for the man's ACCT form being opened was the fact of his imprisonment. However, he told the interviewer that he had felt supported by staff, that the caremap was successful and that he was in contact with family and friends. In answer to the question, "Since your ACCT was closed, how do you occupy your time?" The man said, "In my cell."

In answer to the question printed at the end of the proforma, "Follow up from Safer Custody required?" the "no" box was ticked by the interviewer.

- *Further concerns about the man's state of mind*

On 20 March, the following entry was made in the man's medical record:

> "Anxious and fearful. Anxious that he may lose the house and can't cope. Disturbed sleep. Wakes up with horrible feeling. Anxiety: states already on venlafaxine [an anti-depressant] ... 75mg ... Not relieving his anxiety. Add ..."

The signature of the person who made this entry is illegible.

- *The man is described as very depressed*

On 24 March, an officer wrote in the Staff Observation Book:

> "(The man) very depressed. An officer has spoken to him and arranged for a RMN to see him hopefully today."

At interview, the officer explained that he was on duty in Houseblock 5 with another member of staff who mentioned that he had seen the man looking very depressed. One of the officers was required to complete a task elsewhere in the prison and therefore asked the other to record his concerns about the man in the Staff Observation Book. That officer had seen him at unlock that day and had no undue concerns about him.

At interview, the officer concerned confirmed that he asked his colleague to make an entry in the Staff Observation Book on his behalf after arranging for an RMN to see the man. He said that he had found the man lying on his bed. He asked him how he was. He replied that he felt sick and that this was because his medication was upsetting him. The officer offered to telephone the Healthcare Centre to ask for a RMN to see him and to assess whether his medication could be changed. Although he thought the man was depressed, he did not think it was necessary to open an ACCT form.

There is no written evidence to show that the man was seen by a RMN, although an entry was made in the medical record on 27 March by a doctor listing a number of repeat prescriptions given.

Events on 28 March

- *Mental health assessment cancelled*

On 28 March, the Deputy Head of Healthcare with responsibility for co-ordinating mental health services at Blakenhurst made the following entry in the man's medical record:

> "Appointment for mental health assessment did not occur due to cancellation of clinic."

At interview, the Deputy explained that the man was due to be seen by one of the mental health nurses that day, following an earlier referral. However, he confirmed that the appointment was cancelled because of staff sickness.

- *Committed for trial*

On the same day, the man's bail application was refused because of the possibility that he might fail to reappear at court and that he might commit further offences. The man was remanded in custody to appear in court for trial on 25 May 2006.

- *Dismissal from education classes*

My investigator was presented with a number of transcripts of telephone calls made by the man towards the end of March. According to the log, one such call was made during the afternoon of 28 March. During the call, the man said he had been dismissed from the education classes he had been attending. He claimed that he had been dismissed because he was playing snooker when he should have been in class. It is clear from the transcript that he was upset by this development. My investigator interviewed the Adult Learning Tutor who supervised the man during the education sessions that he did attend. The tutor confirmed that the man missed a number of sessions in March and that he did indeed remove him from classes on or about 24 March after catching him playing snooker at a time when he should have been in class. The tutor explained that prisoners engaged in classes are told from the outset that failure to attend on a regular basis would result in their removal. At interview, the tutor was clear that he gave the man this warning when he joined classes at the end of February. He felt that his decision to sack him was justified in view of the fact the he initially claimed that he could not attend the class because he was having a panic attack and was then caught playing snooker.

At 2:45pm that day, the man made a private telephone call - tape recorded by the prison - in which he said that he felt "absolutely awful". He had hardly slept for the previous two nights and had just been sacked from education. The man also spoke of his worries about his house. He said, "I am just worried absolutely sick. I keep lying down as if it's going to go away and I can't get my head round it." The man explained that he was obsessed, was in deep depression and had ruined everybody's lives.

- *Receipt of distressing letter from house partner*

Also on 28 March, the man received a letter sent the previous day by the woman with whom he co-owned a house. In her letter she wrote about her concerns that her neighbours knew about the circumstance of the man's arrest and about her concerns for her own safety. She alleged that the man was responsible for putting her life in danger.

At 7:20pm that day, the man made another telephone call. This time, he said that he was desperate because he had received a letter from his house partner that he could not answer "because of the court order". The man explained that his partner was saying the he had put her life in danger and that his case had been reported in the press. It is clear from the transcript of the conversation that the man was beside himself with worries about his house, and that these worries were affecting his state of mind. He said:

> "I'm just stuck in a horrible cell all day. Haven't got any painkillers for my back, don't sleep or anything. In the morning I doze for five minutes and wake up feeling absolutely worse that if I had not slept, so I can't win … I'm going absolutely crackers in the meantime. I stuck my head out of a little window waiting to go back to video link, there was some green and some daffodils and it made me

> feel a bit better. Everything in here concrete and horrible floors, stuck in your cell for hours and hours, you are not in the real world, you can't do anything with your energy or adrenalin, it's actually horrible."

My investigator established that, in view of the nature of the man's alleged offences, all of his correspondence was subject to routine monitoring. The letter he received on 28 March was recorded as having been received at Blakenhurst that day and as having been monitored (i.e. read and scrutinised for any child protection issue). The form on which this record was made does not show whether the letter was passed either to the security office or to the office that is responsible for the detailed monitoring of such material. However, my investigator ascertained that neither department was given the letter. It therefore seems likely that, despite its distressing nature, the letter was given to the man without any prior warning of its contents. Thus, wing staff were deprived of an opportunity to offer appropriate support to him. It is clear that receipt of this letter was likely to have been a significant factor in the deterioration of the man's morale just before he died.

- *The man's response to the above letter*

On 30 March, the man drafted a letter to his solicitor about the letter he had received. The man gave instructions to his solicitor about the need for his partner to settle her outstanding debts to him, and with regard to the termination of their joint tenancy. He mentioned in his letter that he was suffering from "dreadful insomnia" and that he usually spent "three nights awake and one night with some sleep". It is clear from the tone of the letter that the man was deeply troubled by the issues about which he was writing.

In a letter he drafted to his brother the same day, he wrote:

> "… My confidence is shattered and I am obviously in the middle of a depressive illness. [My house partner] has written a horrible 'notice' asking urgently to let the house presumably to friends or relatives. I am not allowed to answer, so I have drafted a letter … If you can make sense of the draft letters, please combine them as one, or ring [name deleted]. I think he will decline which means I have lost everything."

None of this correspondence left the man's cell. Staff were therefore not aware of its contents before he died.

The prisoner who shared the man's cell during the three weeks before his death, told my investigator that, although he was often quite low during that period, he never talked about suicide. The cellmate said that on the evening of 30 March, the man was "in a reasonable mood" and was in "fairly good spirits".

Key events on and after 31 March

The cellmate told my investigator that, on 31 March, he got up at about 7:15am. He said that the man rose some time later and got dressed.

An officer told my investigator that somebody from the education department came across to the man's wing during that morning to take a session known as Introduction to Work (ITW). The officer said that the session was a health and safety briefing for those prisoners who might want to take up employment in an industrial workshop. At about 9:30am, the officer spoke to the man and to his cellmate about this session and asked them if they would like to attend. The cellmate was keen to attend but the man said that he had a bad back and preferred to stay in his cell. The man left the cell to attend the session. He remained locked in his cell on his own until lunch time when his cellmate returned for lunch. The officer said that, at this time, the man gave no indication that he was in distress.

The officer explained that lunch is served at about noon on Fridays. Each prisoner collects his meal from a central hotplate in the wing and then returns to his cell to eat it. The officer said that the man would probably have returned to his cell by 12:30pm and would have remained in the cell with his cellmate until about 1:30pm.

The officer explained that prisoners in the man's wing did not normally go to work on Friday afternoons. Instead, they remained in the wing but were allowed to associate freely with other prisoners. At 1:30pm, the man's cell door was unlocked by an officer. As the Introduction to Work session was being held on an upper landing in the wing, the cellmate chose to attend the session rather than to remain on association. The man stayed in his cell, but his door remained unlocked so that he could move about the wing if he chose to do so. The cellmate said that, when he left the cell to return to the health and safety course, the man was laying on his bed, possibly asleep. The cellmate told my investigator that he saw nothing unusual in the man.

At about 4:15pm, the officer was approached by a nurse who had entered the wing to see the man in her role as "CPN2". In this role, the nurse intended to assess the man's mental state following the mental health referrals made earlier. The nurse was taken to the man's cell by the officer. When he arrived at the cell, the officer found the door shut. This was because the man, who had been alone all afternoon, had used his privacy key to lock the door from the inside. (The privacy lock can be overridden by the use of the security keys held by staff.) The officer unlocked the cell door with his key, entered the cell and saw the man suspended form the bed-frame by a ligature made from a towel.

The officer raised a "Code yellow "alarm: a means by which, using the prison radio, staff can draw rapid attention to a life threatening event or situation for which urgent assistance is required. The officer thought that the man's eyes were open but staring downwards. He approached him, lifted his body weight, and cut the ligature with his belt-borne knife. Together with the nurse,

the officer then laid the man on the floor of his cell. The officer called once again for a ”Code yellow” as he could not recall hearing a response on the radio to his earlier call. He described the man as “yellowy”, cold to the touch but without any signs of rigor mortis. The officer let the nurse take over, and as she did so, he asked her if she thought the man was dead. The officer thought that she said he probably was. The nurse told my investigator that the space available to her in the cell was very restricted and that she had to pull the man by his legs so that she could manoeuvre him into a position in which she could commence cardio-pulmonary resuscitation (CPR). As she was doing this, three members of the healthcare staff arrived at the cell with oxygen, a defibrillator and an ambu-bag. As soon as she could, the nurse checked the man’s vital signs. She checked to see whether he was breathing, whether his airways were clear and whether he had a pulse. The nurse said that she could find no signs of life. The man’s complexion was pale and grey but he was not “icy cold”. She applied two emergency breaths and commenced chest compressions. Soon after, another nurse took over the chest compressions while her colleague continued with mouth to mouth resuscitation. Another nurse applied the defibrillator which advised him not to shock. At interview my investigator was told that not all staff were trained in the use of the defibrillator. It was said that at one point a guedal airway was also applied to the man. However, during all these attempts to revive him, the man did not respond.

At about 4:37pm, the prison doctor, arrived. After assessing the situation, he gave instructions for the resuscitation attempts to continue for three more minutes. At about 4:40pm, after further unsuccessful attempts had been made to revive the man, the doctor pronounced him dead.

The log of events kept by the prison shows that an ambulance was called at 4:31pm and that a paramedic crew arrived at 4:40pm, after the doctor had pronounced death. At approximately 4:50pm, the paramedics confirmed death with the use of an electrical trace.

At about 5pm, the police were called. A few minutes later, the chaplain was also contacted. At about 5:07pm, the establishment s Care Team were asked to attend the chapel to be ready to offer support to those staff who needed it. At about 5:10pm, the ambulance crew left the prison. At 9:20pm, the man’s body was removed by undertakers after a forensic examination of his body and cell had been completed by police scenes of crime officers.

The man’s funeral took place on 18 April. His brother requested that no-one from the prison should attend. At interview, the Deputy Governor of Blakenhurst confirmed that no offer had been made by the establishment to contribute towards the costs of the funeral.

Issues

Were the man's health needs adequately met?

- *Medication*

The clinical review notes that the man had a long-term history of depression and was on Venlafaxine 150mg od at home. However, he only received Venlafaxine started on day nine of his admission to Blakenhurst and at a much reduced dose. The clinical reviewer says it is not clear why the man was not continued on Venlafaxine from his first day in custody and at the existing dosage. The reviewer adds, "The concern over the man's anti-depressant management is that the dosage used may have been sub-therapeutic in treating his depression and that there was an increased risk of withdrawal symptoms."

The Governor should ensure that there are adequate arrangements in place for all prisoners to be able to receive their normal or newly prescribed medication within a reasonable time frame. This is especially important for drugs that have important effects if doses are missed (eg: insulin) and/or those that are difficult to order. This should include a review of pharmacy arrangements and policies on how to manage medications while confirmation of dosage is sought from the prisoners GP or specialist.

- *Initial and secondary health screening*

Upon his arrival at Blakenhurst on 13 February 2006, the man underwent a reception health screen by a registered mental nurse. As far as his physical health was concerned, he told the nurse that he was not sleeping well, and that he suffered from arthritis in his knees and shoulder. It was also noted that he was a diabetic. The man was referred to a Wellman clinic, primarily as he was over 50 but also because of his diabetes but there is no evidence that he attended such a clinic.

Where his mental health was concerned, the man disclosed from the outset that he had been an inpatient at a psychiatric hospital in 1992, and that he had a history of depression for which he was currently taking Venlafaxine. The man also disclosed that he took an overdose of drugs when aged 29, and that in 1992 he considered taking a further overdose but did not proceed.

Thus, the initial health screen made it clear that there were both physical and mental issues to be addressed.

In his clinical review of the management of the man's health needs, the clinical reviewer comments as follows:

> "The man was a known diabetic with a history of ischaemic heart disease. There is no record of his pulse or blood pressure being checked during his stay at Blakenhurst.

There is also no record of his blood sugar being checked or any urinalysis. Some of these tests could have been performed as part of the secondary health screen protocol. The form for this is in the medical notes but it is blank suggesting a secondary health screen was never performed.

The secondary health screen previously used to be carried out by the nurses in reception but is now performed by the nurses in the Houseblock 6 (HB6) healthcare centre. The man was initially placed in the Segregation Unit on 13/02/06 and then transferred to the Vulnerable Prisoners Unit (HB5) on 14/02/06 due to the nature of his alleged offence. The majority of prisoners are moved to HB6 not HB5 after the primary health screen in Reception. The man appears to have missed his secondary health screen because he did not pass through HB6.

The man was referred to a Wellman clinic following the primary health screen but there is no record of his attendance at any such clinic. This clinic would have provided another opportunity where pulse/blood pressure measurement and other basic tests could have been performed."

The clinical reviewer makes the following recommendations:

- **There must be systems in place to ensure that all prisoners have both a primary and secondary health screen regardless of where in the prison they are housed. In particular, systems need to be implemented to ensure that those already vulnerable prisoners placed into HB5 receive a secondary health screen. The completion of a primary and secondary health screen for all prisoners should be audited.**

- **There should be systems implemented to ensure that all prisoners referred to a Wellman Clinic are seen at the clinic and there is a record of the attendance and findings in the medical records.**

I concur with these recommendations but would add to the first that paragraph 2.12 of Prison Service Order 3050 requires that every prisoner must be offered a general health assessment in the week following first reception.

- *The man's mental health*

As a result of the information gleaned during the initial health screen about the man's mental health history, a nurse decided to refer him for mental health assessment. At interview, the nurse explained that there were two types of mental health referral: one was for those prisoners whose mental state was such that they needed to be seen by a Community Psychiatric Nurse (CPN) from the In-reach team, and the other was for less serious cases which could be managed by a Registered Mental Nurse (RMN) within the establishment's healthcare team. The nurse could not recall precisely whether or how the man's referral was followed up but thought that he was referred to a RMN.

Two further references to the need for a mental heath intervention were made in the man's medical record. Both were made on 19 February. The first, by a member of the healthcare team whose signature is illegible, was as follows:

> "Spoken to staff on houseblock. They are concerned about the man. – not sleeping, slightly anxious. RMN referral made ... – in court Tuesday 21/2/06 – to discuss i/c doctor x 2-3 days sleeping tablets – once he returns from court – to see the doctor on Wednesday 23 /2/06 – to discuss depression – and anxiety problem."

The second was made by another nurse, who wrote:

> "Seen on HB5 after pill parade at officer request. Spoke to the man briefly. His main concerns seem to be with practical issues such as bill paying etc. It appears his medication requires reviewing as he was on venlafaxine at home and this is not currently prescribed. Complains of poor sleep. To be reviewed by MO re: short term sleeping tablets. Presents as poor coper who wants others to sort out his problems. Mood does seem low. 1st time in prison. Has court videolink on Tuesday. Had depression in Holymoor 1992. Would benefit from superficial level of support from RMN. Referral in place. ACCT already open."

As a result of her consultation with the man on 19 February, the nurse completed a mental health referral form for the man to be seen by a Registered Mental Nurse.

There is no evidence that the man was seen by a RMN at all. On 28 March, more than five weeks after these entries were made, and more than six weeks after the initial health screen had taken place, an entry was made in his medical file to record the fact that a mental health assessment due that day was cancelled because of staff sickness. Thus it seems that he was not seen by a mental health specialist before he died.

In the clinical review, the clinical reviewer writes as follows:

> "It is not clear if a referral form for a mental health assessment was completed following the primary health

screen on 13/02/06. A mental health referral form was completed on 19/2/06. A mental health clinic appointment was made around five weeks after the referral for 28/3/06 but this was cancelled due to staff illness. A RMN was visiting the man in his prison cell for a mental health assessment on 31/03/06 when he was discovered hanging in his cell.

"There are two main options available for prison staff that would like a mental health assessment of a prisoner. They may phone the RMNs asking for an urgent referral and the prisoner is then assessed as soon as possible. A written request form is not required for this approach. Alternatively, a request can be sent using a joint RMN Clinic/Prison In-reach referral form. These referrals are assessed each Tuesday at a joint meeting of the In-reach and RMN clinic teams where referrals are allocated to the appropriate team. The In-reach team policy is to see those with more severe illness eg: severe and enduring mental illness and previous psychotic history. The RMN clinic tends to see prisoners with low mood and anxiety problems. The RMN Clinic referrals then receive their initial assessment in chronological order of the time of referral.

"The service specification of the prison mental health services with the PCT refers to a timeframe of 1 hour for an urgent mental health assessment and 5 days for a routine assessment. The total time specified for the completion of the mental health assessment and care plan is 28 days. The man was not assessed and managed within these specified timeframes."

The clinical reviewer makes the following recommendations:

- **All mental health referrals should be assessed and a care plan completed within the agreed service level agreement timescales. The mental health team should regularly audit its referral and patient care pathways to assess if these timescales are being met and implement all necessary process and other changes to alleviate any unnecessary delays in the time for mental health assessment and care plan completion.**

- **Urgent mental health referrals that are phoned direct to RMNs should require a referral form so that these referrals can be easily audited.**

- **The RMN Clinic team should introduce systems for assessing written referrals with consideration to**

clinical urgency as well as time of referral when deciding how quickly a prisoner should be assessed.

I endorse these recommendations.

Was the man's risk of suicide appropriately assessed monitored and managed?

When the man was held in police custody on 12 February 2006, following his arrest earlier that day, no indication of any risk of self harm was recorded on the detained person's medical form. Neither was there any evidence of any such risk on the Prisoner Escort Report (PER) completed for his journey from court to Blakenhurst the following day. The first indication of a possible risk of self harm was given by the man's Probation Officer in a letter she wrote to the reception manager at Blakenhurst on the same day. In her letter, the Probation Officer described her concern that the man would pose a risk of self harm or suicide because of the fact that for the first time in his life he was about to undergo a period of imprisonment. She also drew attention to her concern that he might stand out from other prisoners as being vulnerable to bullying or intimidation.

This information was acted upon immediately. Despite the fact that the man told a nurse and other reception staff that he did not feel suicidal, a nurse decided to open an ACCT form as a precaution.

I commend both the Probation Officer for her promptness in drawing the attention of reception staff to her concerns about the man's risk of self harm, and the nurse for having the presence of mind to take the precautionary measure of initiating self harm monitoring procedures. I regard these acts as examples of good practice.

My investigator examined in detail the quality of care and support afforded to the man during the period in which the self harm monitoring procedures were in force. On 14 February, the day after the ACCT form was opened, an ACCT assessment interview was conducted with the man by a Senior Officer and a caremap was drawn up. During the interview, the man revealed that his family did not know why he was in prison and that he did not know how they would cope if they found out. He told the Senior Officer that he did not feel suicidal but was low in mood because he had not taken his medication for 36 hours. As result of this discussion, a number of goals for him to achieve were set in the caremap. These were relevant to his needs and were achievable. It is clear from the comments made in the ongoing record in the ACCT form that efforts were made by staff to support him in their achievement. However, no target was set in his caremap in relation to the earlier referral for mental health assessment.

Thereafter, four ACCT case reviews were convened to assess and monitor the man's ongoing risk of self harm or suicide. These took place on 14, 17, 23 February and 2 March. On each occasion, two members of staff attended along with the man himself. Thus, he was consistently given opportunities to be involved in decisions that affected him. This was well managed.

In broad terms, the way in which the man was supported whilst he was considered to be at risk of self harm was satisfactory. However, I draw attention to a number of points of concern.

First, the record of the case review held on 14 February contains a number of minor flaws. It does not indicate whether the frequency of observations to be made of the man had been reviewed. Neither does it show whether his risk was considered to have changed nor whether any of the problems previously identified were reviewed (other than on the caremap).

The Governor should remind staff who make entries in ACCT forms of the need to ensure that <u>all</u> information boxes are completed.

The next review, on 17 February, was to be attended by two specified members of staff. However, neither attended. One of them said he was not told that he should attend. If there is good reason for particular individuals to attend ACCT case reviews, it is essential that poor communication does not prevent their attendance.

The Governor should remind his staff, especially those who chair ACCT case reviews, of the need to communicate decisions and recommendations made at such reviews promptly to all relevant parties.

The record of the final case review held on 2 March that resulted in the closure of the man's ACCT form shows that the post closure review was to be held that day. This was clearly a mistake. The post closure review was, in fact, scheduled to take place on 9 March.

As noted earlier, the questionnaire on the first page recorded that the reason for the man's ACCT form being opened was the fact he was imprisoned for the first time. In answer to the question, "Since your ACCT was closed, how do you occupy your time?" The man said, "In my cell."

Albeit with the benefit of hindsight, I judge that the man's disclosure that he was spending all his time in his cell should have sent a signal to staff that further monitoring of him was necessary. At the very least, a further post closure interview should have been conducted.

The Governor should review his policy for management of post closure reviews to ensure that decisions as to the level of risk and number of post closure reviews required are informed by careful scrutiny of ACCT forms and of the responses given during post closure interviews.

Were staff aware of the despondency the man felt in the last few days of his life? Could they have intervened to prevent his death?

On 28 March 2006, three days before he died, the man was committed for trial and dismissed from his education class. He also received a distressing letter from his house partner, and made two phone calls about its contents.

- *The man's dismissal from his education class*

My investigator's interview with the man's teacher showed that he had been warned in February that he would be dismissed should he fail to attend classes. The tutor felt that his decision to dismiss the man was justified in view of the fact that he initially claimed that he could not attend the class because he was having a panic attack and was then caught playing snooker. I concur with this view. The man was not considered to be at risk of suicide at the time. The tutor had no reason for treating him differently from any other prisoner who failed to attend classes.

- *The man's receipt of a distressing letter from his house partner*

The letter the man received from his house partner on 28 March described his partner's fears for her personal safety after her neighbours had become aware of the nature of his offences. His partner said in the letter that she intended to rent the property out rather than live in it. She said that she wished to discuss matters with the man urgently.

My investigator established that, in view of the nature of the man's alleged offences, all of his correspondence was subject to routine monitoring. The letter he received on 28 March was recorded as having been received at Blakenhurst that day and as having been monitored (i.e. read and scrutinised for any child protection issues). The form on which this record was made does not show whether the letter was passed either to the Security office or to the office that is responsible for the detailed monitoring of such material. However, my investigator ascertained that neither department was given the letter. It therefore seems likely that, despite its distressing nature, the letter was given to the man without any prior warning of its contents. Thus, wing staff were deprived of an opportunity to offer appropriate support to him.

On 30 March, the man drafted a reply to his solicitor about the letter he had received. He gave instructions about the need for his partner to settle her outstanding debts to him and with regard to the termination of their joint tenancy. The man mentioned in his letter that he was suffering from "dreadful insomnia" and that he usually spent "three nights awake and one night with some sleep". It is clear from the tone of the letter that he was deeply troubled by the issues about which he was writing. However, the letter did not leave the man's cell.

- *Telephone calls*

At 2:45pm on 28 March, the man made a private telephone call - tape recorded by the prison - in which he said that he felt "absolutely awful". He had hardly slept for the last two nights and had just been sacked from education. The man also spoke of his worries about his house. He said, "I am just worried absolutely sick. I keep lying down as if it's going to go away and I can't get my head round it." The man explained that he was obsessed, was in deep depression and had ruined everybody's lives.

At 7:20pm, the man made another private call to the same number. This time, he said that he was desperate because he had received a letter from his house partner that he could not answer "because of the court order". The man explained that the house partner was saying he had put her life in danger and that his case had been reported in the press. It is clear from the transcript of the conversation, quoted earlier, that he was beside himself with worries about his house, and that these worries were affecting his state of mind.

Although the telephone conversation was recorded, it was not monitored by staff. Neither were any of the staff aware of the contents of the letter the man had received from his house partner or of his draft reply. I conclude that, as the man did not bring to the attention of staff his feelings about these developments, and because he displayed no obvious signs that he might have been contemplating suicide, staff had no reason to intervene.

Record keeping

The investigation found numerous examples of poor record keeping in the man's medical record. These include:

- illegible signatures
- entries made out of chronological order

The Governor, in conjunction with the Redditch and Bromsgrove Primary Care Trust, should remind healthcare staff of the need to make legible, contemporaneous and chronological entries in prisoners' medical records and that the author of each entry is clearly identifiable.

Funeral costs

The man's funeral took place on 18 April. His brother requested that no-one from the prison should attend. At interview, the Deputy Governor of Blakenhurst confirmed that no offer had been made by the establishment to contribute towards the costs of the funeral.

Paragraph 4.29 of Prison Service Order 2710 requires Governors to offer reasonable funeral expenses to the family.

The Governor should ensure that, in the event of a further death at Blakenhurst, an offer to pay reasonable costs of the funeral is made to the bereaved family, in keeping with the provisions of PSO 2710.

Conclusion

The man had a longstanding record of depressive illness. His healthcare was less than satisfactory, as identified by the clinical reviewer. The clinical reviewer has made a number of recommendations to help prevent such systems failures occurring in the future.

The man was in prison for the first time, and was acutely concerned by developments affecting his life outside prison. However, he gave staff no reason to suppose he was at immediate risk of suicide or self harm while in custody. Having been placed on ACCT, he was able to contribute to his own case planning.

In general, the suicide prevention measures in place at Blakenhurst were satisfactory. However, this tragedy has also drawn attention to shortcomings in particular areas, especially in the healthcare centre.

Recommendations

Communications: ACCT reviews

The Governor should remind his staff, especially those who chair ACCT case reviews, of the need to communicate decisions and recommendations made at such reviews promptly to all relevant parties.

'Post closure interviews

The Governor should review his policy for management of post closure reviews to ensure that decisions as to the level of risk and number of post closure reviews required are informed by careful scrutiny of ACCT forms and of the responses given during post closure interviews.

Record keeping

The Governor, in conjunction with the Redditch and Bromsgrove Primary Care Trust, should remind healthcare staff of the need to make legible, contemporaneous and chronological entries in prisoners' medical records and that the author of each entry is clearly identifiable.

The Governor should remind staff who make entries in ACCT forms of the need to ensure that <u>all</u> information boxes are completed.

Funeral expenses

Funeral expenses should be offered to the man's brother.

The Governor should ensure that, in the event of a further death at Blakenhurst, an offer to pay reasonable costs of the funeral is made to the bereaved family, in keeping with the provisions of PSO 2710.

Good Practice

I commend both the man's Probation Officer for her promptness in drawing the attention of reception staff to her concerns about his risk of self harm, and the nurse concerned for having the presence of mind to take the precautionary measure of initiating self harm monitoring procedures. I regard these acts as examples of good practice.

The recommendations from the Clinical Review are:

- **The Governor should ensure that there are adequate arrangements in place for all prisoners to be able to receive their normal or newly prescribed medication within a reasonable time frame. This is especially important for drugs that have important effects if doses are missed (eg: insulin) and/or those that are difficult to order. This should include a review of pharmacy arrangements and policies on how to manage medications while**

confirmation of dosage is sought from the prisoners GP or specialist.

- **All mental health referrals should be assessed and a care plan completed within the agreed service level agreement timescales. The mental health team should regularly audit its referral and patient care pathways to assess if these timescales are being met and implement all necessary process and other changes to alleviate any unnecessary delays in the time for mental health assessment and care plan completion.**

- **Urgent mental health referrals that are phoned direct to RMNs should require a referral form so that these referrals can be easily audited.**

- **The RMN Clinic team should introduce systems for assessing written referrals with consideration to clinical urgency as well as time of referral when deciding how quickly a prisoner should be assessed.**

- **There must be systems in place to ensure that all prisoners have both a primary and secondary health screen regardless of where in the prison they are housed. In particular, systems need to be implemented to ensure that those already vulnerable prisoners placed into HB5 receive a secondary health screen. The completion of a primary and secondary health screen for all prisoners should be audited.**

- **There should be systems implemented to ensure that all prisoners referred to Wellman Clinic are seen at the clinic and there is a record of the attendance and findings in the medical records.**

- **Staff should be encouraged to maintain high standards of record keeping through audits of record keeping quality.**

At consultation stage, the Prison Service accepted these recommendations.