Investigation into the circumstances surrounding the death of a man at HMP Dovegate in July 2009

Report by the Prisons and Probation Ombudsman for England and Wales

August 2011

This report considers the circumstances surrounding the death of the man at HMP Dovegate in July 2009. He was found in his cell when it was unlocked that morning. He was 48 years old.

I offer my sincere condolences to all those who knew him. I apologise for the very long time taken to issue this report, and any further distress that this may have caused.

The investigation was conducted by my investigator on my behalf. I would like to thank the Director and his staff for their co-operation. I also thank the clinical reviewer who conducted a review of his clinical care. She was appointed by the local Primary Care Trust. The final version of her review was sent to my office in June 2011.

The man received a sentence of imprisonment for life in 1999. He had a history of harming himself and attempting suicide. Whilst in prison but before his transfer to HMP Dovegate, he attempted suicide on two occasions, and harmed himself by cutting his arms a number of times. He was also diagnosed with personality disorders. When transferred to Dovegate in September 2008, he said he felt like harming himself. He did so in November 2008, using a piece of broken glass to cut his arm.

He was prescribed anti-depressant and anti-psychotic medication. He was assessed by a community psychiatric nurse (CPN) but was not offered ongoing support from mental health services.

On 19 June 2009, he moved to Dovegate's therapeutic community. This is separate from the main prison and offers an intensive group therapy setting for serious offenders. On the morning of 9 July, he was found dead in his cell. The cause of his death was not immediately apparent. A post-mortem examination found that he died from aspiration of gastric content caused by quetiapine (an anti-psychotic medication that he was not prescribed) and fluoextine poisoning. I have considered both the possibility that he intended to take his own life, and the possibility that his death was accidental. Unfortunately, I am unable to speak with any certainty about his intentions.

I endorse seven recommendations made by the clinical reviewer, which cover a number of aspects of clinical care including access to mental health services, pain assessment and management, and record keeping.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Thea Walton
Acting Deputy Ombudsman **August 2011**

CONTENTS

Summary

The investigation process

HMP Dovegate

Key events

Issues

Conclusion

Recommendations

SUMMARY

1. The man was sentenced to life imprisonment in 1999. He had a history of convictions for violent offences, and had served a number of previous prison sentences.

2. Before his transfer to HMP Dovegate in September 2008, he spent time in a number of other prisons. He had complex mental health needs over a considerable period of time. He had attempted suicide on a number of occasions before he was imprisoned, both by overdose and by hanging. In 2003 and 2004, he attempted to hang himself whilst at HMP Frankland. He also harmed himself on a number of occasions by cutting his arms.

3. He was assessed in February 2008 for Broadmoor's Dangerous and Severe Personality Disorder (DSPD) unit. The assessment commented on his self-harm and suicide attempts, violent altercations whilst in prison, and his tendency to seek out psychotropic medication. Whilst the assessment concluded that he had antisocial and emotionally unstable personality disorders, he was not considered suitable for admission. This was due to his acts of self-harm, his manipulation of staff to gain access to medication, and his unwillingness to describe his internal world.

4. On 20 August 2008, he harmed himself whilst at HMP Long Lartin by cutting his left arm with a razor. An Assessment Care in Custody and Teamwork (ACCT) was opened to monitor him and offer him additional support. This was closed on 17 September, and he moved to Dovegate the following day. When he arrived, he described himself as worried, distressed, depressed, and thinking about suicide and self-harm. An ACCT was opened and he was admitted to the healthcare unit. He remained in the healthcare unit until 23 October, and on the ACCT until 3 November. He did not harm himself during this period. However, he told members of staff that he heard voices at night telling him to harm himself.

5. He was prescribed fluoxetine, an anti-depressant, and olanzapine, an anti-psychotic medication, when he arrived at Dovegate. He had been taking fluoxetine for a number of years, and olanzapine for around a year. He was reviewed by a community psychiatric nurse (CPN), and an appointment with a psychiatrist was arranged.

6. Although his ACCT was closed on 3 November, he cut his arm using a piece of broken glass later that evening. A new ACCT Plan was opened, and he moved to the healthcare unit. He said he was being bullied and felt his only way out of the situation was to harm himself. The ACCT was closed on 18 November, and he was advised to speak to members of staff on the unit if he had any issues or concerns. During the same period, he was discharged from the psychiatrist's clinic without being assessed, after failing to attend his appointment.

7. He did not harm himself again. Towards the end of 2008, he seemed to mix well with other prisoners when he was on the wing. He was polite to

members of staff and attended education classes. During the first four months of 2009, regular entries were made in his wing history record. There were no major concerns about him, although several references were made to the fact that he spent much of his time in his cell. He did not socialise very much with other prisoners.

8. During May and June, further entries were made in the wing history record. One entry noted that he “rarely leaves his cell other than to collect food”. There were no recorded concerns specifically about his well-being, but it seems that he remained reluctant to socialise with other prisoners.

9. On 19 June, he transferred to Dovegate’s therapeutic community. This is separate from the main prison, offering a group therapy model for serious offenders. There were few entries in his records following this move. An entry in his wing history record on 5 July noted that he had experienced “a bit of a tough week”.

10. There were no further recorded concerns about him. He was found dead in his cell. The cause of his death was not readily apparent. A post-mortem report concluded that he died from aspiration of gastric content caused by quetiapine (an anti-psychotic medication that he was not prescribed) and fluoxetine.

11. The clinical reviewer highlighted a number of issues relating to mental health services, pain management, and information security. I endorse seven recommendations in these areas.

THE INVESTIGATION PROCESS

12. One of my senior investigators was appointed to conduct the investigation on my behalf. Notices of the investigation were sent to the prison for distribution and display, giving staff and prisoners the opportunity to contact him with any relevant information. Nobody came forward as a result.

13. He visited HMP Dovegate to open the investigation on 5 August 2009. He met a number of members of staff and collected paperwork relating to the man's time in custody. This paperwork was considered when conducting the investigation.

14. The local Primary Care Trust asked the clinical reviewer to conduct a review of the man's care whilst in custody. The purpose of a clinical review is to examine the medical care that a prisoner received in custody, which should be an equivalent standard to what might have been expected in the community. She consulted his extensive medical records to inform her review. She wrote in detail about some of the problems experienced in obtaining paperwork, and noted that her review was made very difficult as a result of poor record keeping. The final version of her clinical review was received by my office in June 2011.

15. Members of staff from HMP Dovegate asked Staffordshire Police to assist them in tracing any living relatives of the man. Their efforts proved fruitless.

16. My investigator contacted Her Majesty's Coroner for South Staffordshire to inform him of the nature and scope of the investigation and request a copy of the post-mortem report. My report will be sent to the coroner to assist his enquiries into his death.

HMP DOVEGATE

17. Dovegate is located in Uttoxeter, Staffordshire. It is managed by Serco, a private company, under contract to the National Offender Management Service (NOMS). It holds up to 860 adult male offenders in the main prison. A further 200 are accommodated in the therapeutic community, an intensive group therapy environment for those convicted of serious offences and assessed as suitable for inclusion.

Performance

18. HM Chief Inspector of Prisons last reported on Dovegate following an announced inspection in October 2008. She said that:

> "On our last two visits to the main prison, we noted serious weaknesses in safety and control and a lack of progress between inspections. To the credit of the Director and his staff, this full announced inspection found a safer and more controlled prison with reasonable purposeful activity, although resettlement remained weak.
>
> "The establishment was now much better ordered and considerable efforts had been made to tackle bullying. A strong emphasis had been placed on security, and this was not disproportionately affecting the regime for prisoners. Staff appeared more confident and there had been a substantial reduction in the use of force."

19. She made the following comment about healthcare services at Dovegate:

> "Primary health services were reasonable, but were compromised by shortages of staff and accommodation, which needed a substantial increase in funding for healthcare to move forward. Chronic disease management was maintained despite staff shortages, but staff needed more time to give a quality service to prisoners. Many NHS appointments were cancelled or rearranged, and pharmacy services needed further development. Nursing staff administered medications on their own, which was unsafe. Mental health services were good and developing, and prisoners were well supported by the primary and secondary services."

20. The therapeutic community was inspected separately in June 2008. She reported that:

> "The TC was … a generally safe place. It remained a struggle to ensure sufficient applicants to the TC, but once at Dovegate, assessment and induction were thorough. Levels of self-harm were low, although the TC had recently suffered its first apparently self-inflicted death. Bullying did not appear to be a major issue, but there was evidence of an increase in the use and availability of drugs."

Previous deaths at HMP Dovegate

21. This was the ninth death to have occurred at Dovegate since April 2004, when the Ombudsman began investigating all deaths in prison custody in England and Wales. Since the man's death, there have been four further deaths at Dovegate. Following the death of a prisoner in March 2009, I made a recommendation aimed at improving the standard of clinical record keeping. I return to the same issue as part of this report.

KEY EVENTS

22. The man was sentenced to life imprisonment for murder in 1999. He had a history of violent convictions and had served previous prison sentences.

23. Before his transfer to Dovegate in September 2008, he spent time in a number of other prisons. In her review of his clinical care, the clinical reviewer summarised his contact with mental health services. She described him as having "complex health related needs over a considerable period of time". She examined his medical records and found that he had attempted suicide by overdose on two occasions prior to his imprisonment. He had also attempted to hang himself on three occasions, once before his imprisonment, and twice more in 2003 and 2004 whilst at HMP Frankland. He also harmed himself on numerous occasions whilst in custody by cutting his arms.

24. In February 2008, his suitability for Broadmoor's Dangerous and Severe Personality Disorder (DSPD) unit was assessed. She noted in her clinical review that the assessment referred to the considerable period of time that he had spent in custody, his history of self-harm and attempted suicide, and the various types of psychotropic medication that he had sought out and had subsequently found it difficult to withdraw from. The assessment also commented on his history of violence, including a premeditated assault in custody in 2000, during which he stabbed another prisoner with a pair of scissors. He was diagnosed with antisocial and emotionally unstable personality disorders, with features of a paranoid personality. However, he was not considered suitable for admission. The assessors wrote:

> "While we agree that the man suffers from at least two personality disorders which are clearly linked to his violent and offending behaviour and he is at risk of re-offending, we also had some concerns about his suitability for the DSPD service at Broadmoor. These relate to: his recurrent acts and threats of self-harm; his manipulation of staff to obtain medication to alleviate his negative emotions; his potential capacity to split staff and other patients and his unwillingness/inability to access and describe his internal world."

25. He therefore remained in the prison system. On 20 August 2008, whilst at HMP Long Lartin, he harmed himself by cutting his left arm with a razor. As a result, the Assessment, Care in Custody and Teamwork (ACCT) was started. The purpose of an ACCT is to ensure the safety of prisoners at risk of self-harm or suicide, and often involves additional support and monitoring. The process also includes regular reviews. During his time on the ACCT, he did not harm himself. During a review on 16 September, he was described as "upbeat about a proposed move to Dovegate". The next day, his ACCT was closed.

26. He transferred to Dovegate on 18 September 2008. Whilst at Long Lartin, he had been seen by the Worcestershire mental health in-reach team and the clinical manager had identified him as having complex needs, a history of self-harming behaviour, and self-reported auditory hallucinations. This

information, along with care plans, was sent to the Mental Health Foundation Trust at the time of his transfer to Dovegate.

27. When he arrived at Dovegate, he said he felt worried, distressed and depressed and had thoughts of suicide and self-harm. An ACCT Plan was opened and he was admitted to the healthcare unit. He remained in the healthcare unit until 23 October, and on the ACCT Plan until 3 November. He did not harm himself during this time. Seven reviews of the plan were conducted, and he appeared to become more settled as time passed. However, he continued to tell members of staff that he heard voices at night telling him to harm himself.

28. The clinical reviewer reviewed medical interventions for him following his transfer to Dovegate. She noted that he was prescribed olanzapine, an anti-psychotic medication, and fluoxetine, an anti-depressant. He had been prescribed these medications for a number of years. Although the medical notes were incomplete, it appeared that he began taking fluoxetine in May 2003, and olanzapine in October 2007. The healthcare team agreed that he would be reviewed monthly by a community psychiatric nurse (CPN) and referred to a psychiatrist for assessment. After assessing him on 17 October, the CPN concluded that he did not have an enduring mental illness, but recognised that he had long been prescribed anti-psychotic and anti-depressant medication due to a history of depression and self-harming behaviour. He was reviewed by the CPN on 23 October. The possibility of discharge from the in-reach team was discussed by the multi-disciplinary panel. An appointment with a psychiatrist was arranged for early November.

29. Although his ACCT was closed on 3 November, he cut his arm using glass from a broken coffee jar later the same evening. A new ACCT was opened and he moved to the healthcare unit. He said he was being bullied and felt his only way out of the situation was to harm himself. After reviews on 4 November, 11 November and 18 November, the ACCT was closed. He had moved to a different unit and said he was settling well, with no thoughts of self-harm. He was advised to speak to members of unit staff if he had any issues or concerns.

30. During the same period, he was discharged from the psychiatrist's clinic without being assessed, after failing to attend his appointment. The clinical reviewer wrote in her clinical review that he had refused to attend for the planned assessment on 11 November. He was discharged from the mental health in-reach team on 28 November.

31. There were no further recorded incidents of him harming himself between November 2008 and July 2009. After the closure of his ACCT in November, there was little of note recorded for the remainder of the year in terms of concerns about his well-being. Regular entries were made in his wing history record which suggested that he was polite to members of staff, mixed well with other prisoners, and was participating in education.

32. On 7 January 2009, he moved to the healthcare unit after complaining that he was being bullied on the unit. He remained in the healthcare unit until 9 February. During this period, members of staff noted in the wing history record that he spoke to them only when he wanted something, and was reluctant to mix with other prisoners.

33. He moved to a new unit on 9 February. Regular entries were made in his wing history record throughout February, March and April. Officers reported that he was polite, but did not tend to socialise with other prisoners and spent much of his time in his cell. However, there were no major concerns about his well-being. On 29 April, he again moved units.

34. During May and early June, a number of entries were made in his wing history record. One such entry noted that "he rarely leaves his cell other than to collect food". Although there were no major concerns about his well-being, he remained reluctant to socialise.

35. Throughout this time, he had been receiving his prescribed medication. It was given to him daily, and he did not keep it in his possession. The last entry in his clinical record was on 3 June, and indicated that he had not collected his medication that afternoon. There was no indication that this was an ongoing problem, although the clinical reviewer noted in her clinical review that there were some gaps in the documentation of the administration of his medication.

36. On 19 June, he was transferred to Dovegate's therapeutic community for assessment. The therapeutic community is separate to the main prison, taking serious offenders and offering a group therapy treatment model. The community challenges entrenched attitudes to offending, exposes the suffering of victims and works towards change. The group therapy is intensive and prisoners are assessed for suitability.

37. There is limited information in his prison records about his time in Dovegate's therapeutic community during late June and early July. Information about things like, for example, his level of interaction with staff and other prisoners, was not recorded as frequently as it had been before the move.

38. A probation officer at Dovegate wrote a sentence planning and review report on 25 June. She wrote:

> "Now that the man is located in the [therapeutic community] and is being assessed, future targets will depend on the outcome of this assessment, and whether he is suitable for therapy. Having interviewed him, he would appear to be a likely candidate for therapy and in my view he would gain considerably from this."

39. Following his move to the therapeutic community, a single entry was made in his wing history record on 5 July. This stated that he had experienced "a bit of a tough week" and had not attended all the groups that he was meant to, but that he remained polite and respectful towards members of staff.

40. No further concerns were recorded about him in his wing history record or his clinical record.

41. One morning his cell was opened at around 7.45am along with the others on the wing. A Prisoner Custody Officer (PCO) found him lying on the floor of the cell. He was unresponsive. She and her colleagues began cardio pulmonary resuscitation, and this was continued by paramedics when they arrived at 8.00am. The attempts at resuscitation were unsuccessful, and the paramedics declared at 8.25am that he had died.

42. The cause of his death was not immediately obvious. A post-mortem report was completed and concluding that he died from aspiration of gastric content caused by quetiapine and fluoxetine poisoning. Quetiapine is an anti-psychotic medication which was not prescribed for him. This issue is discussed in the following section.

43. The prison and Staffordshire Police attempted to find surviving relatives of his but were unsuccessful. The funeral was therefore organised by the prison and took place on 27 July 2009.

ISSUES

Clinical care

44. The clinical reviewer, from the local Primary Care Trust (PCT), conducted a review of the man's clinical care whilst in custody. I refer to her findings in this section.

Provision of mental health services

45. There is evidence that he had input from mental health services over a significant period of time. In February 2008 he was assessed by the admission team at Broadmoor hospital and was diagnosed with two personality disorders. He worked with the mental health in-reach team from the Mental Health Trust and, when transferred to Dovegate, with the Health Foundation Trust.

46. He arrived at Dovegate on 18 September. By the end of November, he had been discharged from the in-reach team's caseload, having been assessed by a CPN and refusing to attend an appointment with a psychiatrist. He had been on an open ACCT almost continuously since his arrival at Dovegate, had reported hearing voices, and had harmed himself using a piece of broken glass. By early January 2009, he was discharged from the prison's primary mental health services and so received no mental health support other than his regular medication. Given the relatively short period of time that he had been at Dovegate and his obvious needs, she thought that discharge from mental health services may have been premature. However, there were no further recorded incidents of self-harm between November 2008 and July 2009.

47. In her clinical review, she notes that patients in the community would usually be offered a further appointment with a psychiatrist before being discharged from the clinic.

48. I endorse the following recommendation made by the clinical reviewer.

The mental health in-reach provider should consider reviewing existing standards relating to 'did not attend' and discharge from the caseload, to ensure equity of access to services for those in prison. These standards should be clarified with Dovegate as part of an agreed protocol.

Medication

49. When he arrived at Dovegate, he was taking fluoxetine and olanzapine, having been prescribed these medications for a number of years. He continued to receive both medications on prescription until the time of his death.

50. The clinical reviewer noted that he was diagnosed with personality disorders but not with depression. She therefore questioned the rationale behind him being prescribed anti-depressants, particularly at the highest recommended therapeutic dosage. She further commented that patients in the community prescribed such a level of fluoxetine would ordinarily be reviewed by their GP every month or every two months. For him, such reviews were infrequent and coincided with him seeing a doctor for other reasons. The last medication review was dated 15 September 2008, meaning that no reviews took place at Dovegate, other than when he was first transferred there. This was, therefore, not equitable with the level of care that would be expected in the community. I endorse the following recommendations.

The Head of Healthcare should consider devising a process to facilitate and/or trigger regular review of those being treated for depression and/or on regular medication.

The Head of Healthcare should, in conjunction with the commissioner of healthcare services, consider reviewing procedures for the application of guidance relating to managing depression.

51. The clinical reviewer found no documented reason for the repeat prescribing and administration of olanzapine to him. He had been prescribed olanzapine since October 2007 and, during his assessment for Broadmoor hospital, said he got considerable benefit from the medication as he believed that it calmed him down. However, there were no apparent reviews of the suitability of this medication following his transfer to Dovegate, and no stated reason in the clinical record of why he continued to have it prescribed.

52. In addition to his anti-depressant and anti-psychotic medications, he had a long history of seeking out opiate analgesia (pain relief) for various aches and pains. He had a repeat prescription for co-codamol, which is composed of codeine and paracetamol. The clinical reviewer found no evidence of specific pain assessments during his entire history of imprisonment, despite healthcare staff repeatedly prescribing pain relief medication. I endorse her recommendation in this area.

The Head of Healthcare should consider introducing simple pain assessment (and accompanying training) as standard, to be utilised within consultations where pain is presented.

53. Regarding administration of his medication, the clinical reviewer found gaps in the documentation. It was, therefore, unclear if his medication had been administered. There were spells during which administration of medication was not documented, as well as other sporadic instances.

54. I endorse the following recommendation made by the clinical reviewer with regard to medication.

The Head of Healthcare should ensure that robust standard operating procedures are in place, to provide assurance that medication is

managed safely. These operating procedures should cover the prescribing, procuring, record keeping, administration and disposal of all medication.

Record keeping

55. The clinical reviewer wrote in her clinical review that the standard of record keeping was a source of concern. In particular, this related to handwritten notes and records of management practices at both a clinical and organisational level. It was not possible to coherently read significant sections of the original records. Whilst handwritten notes were dated, they were not signed clearly or legibly in some cases, and times were frequently omitted. Treatment sheets deviated from the accepted standards of the Medicine Administration and Documentation Code.

56. When she received his clinical record, it was incomplete. The entire record accounting for the period February to July 2009 was missing. This was later provided, though no explanation was given for its loss and eventual recovery. Her documents were a copy of the clinical record. When she asked to see the original, she was told that its whereabouts were not known. In her clinical review, she said she had concerns about the way in which the clinical record had been handled following the man's death. I endorse her recommendations in this area.

The Head of Healthcare should undertake an audit of documentation standards to ensure that record keeping is in line with the guidance set out by the Nursing and Midwifery Council.

The Director and Head of Healthcare should review existing procedures and protocols for the security and effective management of records following a death.

Issues arising from the post-mortem report

57. The man died as a result of aspiration of gastric content, caused by fluoxetine and quetiapine poisoning. Whilst he had been prescribed fluoxetine for a number of years, he had not been prescribed quetiapine, an anti-psychotic medication.

58. He received his medication on a daily basis and was not permitted to retain stocks of it in his cell. The clinical reviewer noted in her clinical review that quetiapine was stocked by the prison, but was not given to prisoners to keep in their cells. Quetiapine would be given to prisoners with a prescription on a day by day basis, in the same way as he received his prescribed medication. The clinical review reported that a small number of prisoners were prescribed quetiapine between September 2008 and July 2009.

59. It is unclear how he came to be in possession of quetiapine. She found that the prison was keeping a "relatively high level" of the medication and said that whilst some medications were kept 'in stock' to allow rapid access, they

should be kept to a minimum and used only in urgent situations. She mentioned in her clinical review that the situation might be improved by a review of the pharmacy arrangements and the provision of an on-site pharmacist.

The man's cause of death

60. Although I have considered the issue of whether he intended to take his own life, I cannot say with any certainty if this was the case. He had attempted suicide on more than one occasion, though these attempts were made some years earlier. Two attempts were by overdose, but were more than ten years prior to his death. Additionally, he had harmed himself, usually by making cuts to his arms. When he arrived at Dovegate, he said he felt worried, distressed and depressed, and had thoughts of suicide and self-harm. He also said he heard voices at night. On 3 November 2008, he cut his arm using a piece of broken glass. However, he did not harm himself again after that occasion.

61. The clinical reviewer noted in her clinical review that he had a history of seeking out medication, usually opiate pain relief. It is unclear how he came to possess quetiapine, an anti-psychotic medication. He had been taking a relatively high dosage of fluoextine for a number of years.

62. He may have taken this combination of medications in an attempt to end his life, though the possibility exists that he did not anticipate the adverse effects and that his death was accidental.

CONCLUSION

63. The man was serving a sentence of imprisonment for life, and had been in custody for ten years at the time of his death. He had a history of self-harm and attempting suicide. In addition, he was known to seek out prescription medications, particularly opiate-based pain relief. He had a long history of mental health issues, and had been diagnosed with personality disorders.

64. At the time of his death, he was prescribed anti-depressant and anti-psychotic medication. He had recently moved to the therapeutic community. He was found collapsed in his cell in July 2009. Resuscitation attempts were unsuccessful.

65. A post-mortem examination found that he died from aspiration of gastric content caused by quetiapine and fluoxetine poisoning. Quetiapine is an anti-psychotic medication that was not prescribed to him. He was prescribed fluoxetine, an anti-depressant. It is not possible to say with any certainty whether he intended to take his own life, or whether his death was accidental. I am sure the inquest will consider this matter further.

RECOMMENDATIONS

1. The mental health in-reach provider should consider reviewing existing standards relating to 'did not attend' and discharge from the caseload, to ensure equity of access to services for those in prison. These standards should be clarified with Dovegate as part of an agreed protocol.

   The recommendation was partially accepted. In-reach services are compliant with their own Foundation Trust protocol. The first 'did not attend' is followed up, with reasons established. A second 'did not attend' results in a referral back to primary care. HMP Dovegate should ensure that they comply with their own Trust protocol.

2. The Head of Healthcare should consider devising a process to facilitate and/or trigger regular review of those being treated for depression and/or on regular medication.

   The recommendation was accepted. The service specification for mental health will be reviewed and will incorporate a list of agreed interventions according to health need and nurse capability. This will include a whole team and integrated approach with primary care GP services.

3. The Head of Healthcare should, in conjunction with the commissioner of healthcare services, consider reviewing procedures for the application of guidance relating to managing depression.

   The recommendation was accepted. The service specification for mental health will be reviewed and will incorporate a list of agreed interventions according to health need and nurse capability.

4. The Head of Healthcare should consider introducing simple pain assessment (and accompanying training) as standard, to be utilised within consultations where pain is presented.

   The recommendation was accepted. The primary care lead will source an appropriate and evidence-based tool and ensure that all members of staff are instructed in its use. Pain management clinics will be evident as part of chronic disease management.

5. The Head of Healthcare should ensure that robust standard operating procedures are in place, to provide assurance that medication is managed safely. These operating procedures should cover the prescribing, procuring, record keeping, administration and disposal of all medication.

   The recommendation was accepted. Medicines management will be implemented by the deputy healthcare manager by September 2011, and will include all key stakeholders. The process of prescribing, dispensing and administering medications will be fully reviewed.

6. The Head of Healthcare should undertake an audit of documentation standards to ensure that record keeping is in line with the guidance set out by the Nursing and Midwifery Council.

   The recommendation was accepted. An electronic clinical records system has now been implemented.

7. The Director and Head of Healthcare should review existing procedures and protocols for the security and effective management of records following a death.

   The recommendation was accepted. The policy will be reviewed in the context of a new electronic clinical records system having been implemented.