Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Rodney Blair a prisoner at HMP Pentonville on 2 August 2015

A report by the Prisons and Probation Ombudsman
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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Blair was found hanged in his cell at HMP Pentonville on 2 August 2015. He was 40 years old. I offer my condolences to Mr Blair's family and friends.

The investigation found that Mr Blair received some good support from specialist staff at Pentonville, but some potentially important interventions were missed and his risk factors for suicide were not fully considered when he first arrived. Mr Blair also did not have a structured assessment when he reported ongoing alcohol withdrawal symptoms after completing an alcohol detoxification programme and no one reviewed his medication and re-prescribed him an antidepressant, when it was established he had been prescribed such medication in the community.

Nevertheless, I consider there was little to indicate to staff that Mr Blair was at imminent risk of suicide and it would have been difficult to predict his actions and prevent his death.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **March 2016**

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Summary

Events

1. Mr Rodney Blair was remanded to HMP Pentonville on 30 June 2015. He had been diagnosed with schizophrenia about 20 years earlier, although his community psychiatrist had stopped his antipsychotic medication three months before he went to prison. Mr Blair frequently misused alcohol and cannabis and began an alcohol detoxification programme when he arrived at Pentonville. He had no record of self-harm. He told the reception nurse he had considered suicide in the past, but no longer had such thoughts. The nurse and other reception staff did not consider he was at risk of suicide or self-harm.

2. On 7 July, Mr Blair completed the detoxification programme, but said several times in the following weeks that he still had some withdrawal symptoms. No one reviewed his medication or formally assessed his symptoms again. He often said he was very worried about losing his flat but his mental health and drug worker assured him that his tenancy was safe while he was on remand.

3. On the evening of 2 August, an officer found Mr Blair had hanged himself. Prison and healthcare staff began cardiopulmonary resuscitation but, after further emergency treatment, paramedics confirmed that Mr Blair had died. The duty governor asked the police to break the news of Mr Blair's death to his parents.

4. After Mr Blair died, three prisoners alleged that several prison officers had made inappropriate and abusive comments to Mr Blair on 2 August, when he had spent much of the day calling them to his cell to ask for medication. (One prisoner later withdrew his evidence.) The officers denied this and said they had little contact with Mr Blair that day. Records show that Mr Blair did not use his cell bell to call officers all day.

Findings

5. It was a matter of judgement whether Mr Blair needed to be monitored as a risk of suicide when he first arrived at the prison, but we found little evidence that reception staff fully understood or considered Mr Blair's risk factors for suicide when they initially assessed him. Mr Blair was evidently anxious about his housing situation and sometimes found it difficult to cope with alcohol withdrawal symptoms. While his mental health problems meant he was always at some risk of suicide, in the days leading up to his death, there was little to indicate that he was at raised or imminent risk. However, healthcare staff missed opportunities to review his medication and formally assess his withdrawal symptoms.

6. We have been unable to establish exactly what happened on 2 August; although the prisoners' accounts were broadly consistent and, if true, would indicate poor professional standards on the part of officers, some aspects of their accounts lacked credibility and were contradicted by other evidence. Contrary to national instructions, the prison asked the police to inform Mr Blair's family of his death rather than prison staff.

Recommendations

- The Governor should ensure that reception staff have a clear understanding of their responsibilities and the need to share all relevant information about risk, and that they consider and record all the known risk factors of a newly arrived prisoner when determining the risk of suicide and self-harm.
- The Head of Healthcare should ensure that a GP reviews prisoners' medication, when it is confirmed that they have been prescribed medication in the community.
- The Head of Healthcare should ensure that clinical assessments of withdrawal symptoms are completed when prisoners who have finished an alcohol detoxification programme report difficulties with ongoing symptoms.
- The Governor should ensure that, where possible, a member of Prison Service staff informs a prisoner's family quickly and in person of their death, in line with national instructions.

The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Pentonville informing them of the investigation and asking anyone with relevant information to contact him. Three prisoners responded.

8. The investigator visited Pentonville on 5 August. He obtained copies of relevant extracts from Mr Blair's prison and medical records and spoke to the three prisoners who had come forward. He interviewed 11 members of staff at Pentonville in September and October.

9. NHS England commissioned a clinical reviewer to review Mr Blair's clinical care at the prison. She joined the investigator for interviews with clinical staff.

10. We informed HM Coroner for Inner North London of the investigation and have sent the coroner a copy of this report.

11. One of the Ombudsman's family liaison officers contacted Mr Blair's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Blair's mother asked about the timeline of events during his time in prison and leading up to his death. She asked what medication he received in prison and whether the prison had access to his medical records.

12. Mr Blair's family received a copy of the initial report. They raised a number of questions that do not impact on the factual accuracy of the report and which we have addressed separately.

Background Information

HMP Pentonville

13. HMP Pentonville is a local prison that holds close to 1,300 young adult and adult men. The prison primarily serves the courts of north and east London.

HM Inspectorate of Prisons

14. The most recent inspection of HMP Pentonville was in February 2015. Inspectors had serious concerns about poor living conditions and safety at the prison. Inspectors witnessed some indifferent responses to prisoners in need and prisoners were frustrated about their inability to get things done. Landing staff had little interaction with prisoners during the limited amount of time they were unlocked. Cell bells were not answered promptly. The number of prisoners managed under ACCT suicide and self-harm prevention procedures was relatively low. Prisoners with substance misuse problems received good clinical care and the stabilisation unit on F Wing (where Mr Blair lived) provided a safe environment. Inspectors noted that working relations between prison and mental health staff were effective but few officers had received mental health training. Primary mental health services were adequate and secondary mental health and day care services were good.

Independent Monitoring Board

15. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to March 2015, the IMB reported that healthcare services were delivered reasonably efficiently. They reported that prisoners on F Wing were generally happier than on other wings and were often reluctant to move to other wings when their treatment had finished. The IMB reported that incidents of self-harm in the prison had fallen by nearly a third over the year.

Previous deaths at HMP Pentonville

16. Mr Blair was the fourth prisoner to die at Pentonville since June 2014, the second apparently self-inflicted death. In our investigation into the death of a man in December 2014, we found that prison staff did not fully consider his risk factors for suicide and self-harm when he arrived at Pentonville.

Assessment, Care in Custody and Teamwork

17. Assessment, Care in Custody and Teamwork (ACCT) is the is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multi-disciplinary case reviews involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

18. Mr Rodney Blair had been diagnosed with schizophrenia in the 1990s. He was under the care of the Enfield Community Mental Health Team and, for a number of years, received a monthly depot injection. (A depot injection slowly releases antipsychotic medication into the body over a number of weeks.) A community psychiatrist stopped the depot injection in March 2015, as the medication Mr Blair had been taking was no longer available and he appeared settled. After that, Mr Blair was prescribed only an antidepressant. He regularly saw a dual diagnosis worker in the community because of his misuse of alcohol and cannabis. (Dual diagnosis is the term used for patients with both severe mental illness - mainly psychotic disorders - and problematic drug and/or alcohol use.) Mr Blair had been in prison once before, in 2013, when he had served a six month sentence at Pentonville.

19. On 28 June 2015, Mr Blair was arrested for possessing a knife in a public place and was remanded to Pentonville on 30 June. His Person Escort Record (PER, a document that accompanies prisoners on all journeys to communicate information, including about risk factors) stated that Mr Blair had schizophrenia, but identified no other risks.

20. At an initial health screen, a nurse noted his diagnosis and that a psychiatrist had recently stopped his depot medication. Mr Blair said he had recently been prescribed antidepressant medication, but did not currently have any, as he had been asked to leave his community GP due to his behaviour. Mr Blair said he drank alcohol every day. Mr Blair said that he had never previously harmed himself and had no current thoughts of self-harm. He said that he had had some suicidal thoughts in the past. (The nurse could not remember if he had discussed the circumstances of these with him.) The nurse said he did not see the PER, which was often the case. He referred Mr Blair to the reception GP for detoxification from alcohol, and to the prison's mental health in-reach team.

21. Later that evening, the reception GP assessed Mr Blair and prescribed medication, including chlordiazepoxide (to reduce anxiety and for acute alcohol withdrawal) and vitamin supplements, for a week-long alcohol detoxification programme. Prison staff allocated Mr Blair a cell on F Wing, the stabilisation unit for prisoners with substance misuse problems.

22. On 1 July, a dual diagnosis worker at Pentonville saw Mr Blair so that he could sign consent forms for the prison to obtain his community medical information. She noted that Mr Blair did not appear to be withdrawing from alcohol and had no immediate concerns about his mental health. Mr Blair said he would like to engage with mental health support groups, and she added him to a support group for prisoners with mental health diagnoses.

23. On 2 July, an assistant psychologist saw Mr Blair for a mental health triage assessment. She noted that Mr Blair appeared to have little insight into his mental health and tried to change the subject whenever she asked him about it. Mr Blair denied that he had alcohol problems and said he only drank when he was bored. He said he was worried he would lose his flat because he was in prison. She noted that they would discuss Mr Blair's case at the mental health

team's weekly multidisciplinary team meeting. She later contacted Mr Blair's community care coordinator, who agreed to send her details of his diagnosis and treatment.

24. The community care coordinator emailed the psychologist a summary of Mr Blair's diagnosis and treatment on 3 July. This said that Mr Blair was prescribed an antidepressant and had a medication review scheduled in the community for 7 July. The psychologist did not scan the information into his electronic medical record or note it in the record.

25. On 7 July, the multidisciplinary team meeting, including a prison psychiatrist, the psychologist and the dual diagnosis worker, discussed Mr Blair. The psychiatrist noted that they had concluded that Mr Blair's main issue was alcohol dependence, that he should be included on the dual diagnosis worker's caseload and that there was no need for any further input from the mental health in-reach team at the time. There was no discussion about prescribing an antidepressant and no one reviewed Mr Blair's medication.

26. Later that day, the dual diagnosis worker reviewed Mr Blair who told her that he did not think he had a problem with alcohol. He said he had not experienced any psychotic symptoms since the community psychiatrist had stopped his depot injection. She recorded that Mr Blair's main concern was that he would lose his flat because his alleged offence had involved an altercation with a neighbour. She referred him to St Mungo's, a charity that helps prisoners with urgent housing needs.

27. Mr Blair completed the alcohol detoxification programme on 7 July. He did not report any problems at the time. Mr Blair was not prescribed any more medication while he was at Pentonville.

28. On 10 July, Mr Blair had a court hearing by video link. The magistrate refused bail and scheduled a further hearing for 5 August. Mr Blair later told a healthcare support worker that he was annoyed that he had not go bail, and he did not think his solicitor had supported him as well as he could have done.

29. That day, Mr Blair's community dual diagnosis caseworker emailed a summary of Mr Blair's diagnosis and treatment to the dual diagnosis worker. This was similar to that the community care coordinator had sent to her and again said that Mr Blair was prescribed an antidepressant. She did not enter this information in his electronic medical record.

30. On 13 July, an alcohol support worker reviewed Mr Blair. They discussed alcohol awareness and she noted that he engaged well.

31. On 14 July, Mr Blair smashed his television and said that this was because he had been to the treatment hatch and had not been given medication. (Since finishing his alcohol detoxification, Mr Blair he had not been prescribed any medication.) Prison staff reduced his incentives and earned privileges level (IEP, a scheme designed to encourage and reward good behaviour in prisons) to basic for a week as a result. (Basic is the lowest tier of the IEP scheme and meant, for example, that Mr Blair could not have a television in his cell and had more

restricted time out of cell.) No member of healthcare staff assessed Mr Blair that day.

32. On 16 July, Mr Blair attended the psychologist's clinic and said goodbye by telephone to his community dual diagnosis worker, who was leaving the service. The psychologist noted that Mr Blair had been very upset because he said that a psychiatrist had told him he did not have schizophrenia and had stopped his antipsychotic medication before he came to prison. (There is nothing in the records we have seen to suggest that a psychiatrist ever changed Mr Blair's diagnosis of schizophrenia.) Mr Blair told her that he was finding his detoxification from alcohol difficult. She noted that the multidisciplinary team would discuss Mr Blair's medication at their next meeting. She also put a 'task' on his medical record asking a substance misuse nurse to assess Mr Blair. (We do not know when anyone from the substance misuse team saw the task, but no one from the substance misuse team saw Mr Blair for another week.)

33. The psychologist said that the multidisciplinary team discussed Mr Blair's case at their meeting on 21 July and agreed that the substance misuse GP should review Mr Blair's medication and consider prescribing medication for anxiety. There is no note of any discussion about Mr Blair in the minutes of the meeting and a GP did not seem him afterwards. The GP did not recall discussing Mr Blair at any meeting other than that on 7 July.

34. On 23 July, a substance misuse nurse assessed Mr Blair, after the psychologist's request of 16 July. He noted that Mr Blair had completed his detoxification programme but had some physical symptoms of withdrawal. He did not record what the symptoms were, or what Mr Blair said about his withdrawal, but noted that he had encouraged Mr Blair to attend group work.

35. On 28 July, Mr Blair told an officer that he expected to be released soon and was worried about whether he would be able to keep his flat. He asked him to phone the psychologist so he could speak to her about this. She visited Mr Blair later that day and noted that Mr Blair had been very aggressive and wanted her to confirm his housing situation, but she had explained that this was not within her remit. She told him that she would ask the community care coordinator to visit.

36. The next day, 29 July, the psychologist spoke to the dual diagnosis worker about Mr Blair's concerns. The dual diagnosis worker spoke to a caseworker at St Mungo's and emphasised that Mr Blair believed he would be released soon and was anxious about his housing. The caseworker told her that he would visit Mr Blair but Mr Blair's flat would be kept available for him while he was on remand. (There is no record that he saw Mr Blair before he died.)

37. Mr Blair phoned his parents that afternoon. Prisoners' telephone calls are recorded but, unless there are specific security concerns, prison staff listen to only a random sample. We listened to recordings of Mr Blair's calls. That day, Mr Blair told his father that he felt "100 per cent" now he was not drinking. He said he might be released at his court appearance on 5 August, but he was worried as he did not know whether he would be able to keep his flat.

38. On 29 July Mr Blair's cellmate was released. No one else shared the cell with him and he was alone in the cell until his death.

39. On 30 July Mr Blair had an appointment with his community care coordinator, who was visiting Pentonville that day. Mr Blair went to the healthcare centre before the appointment, but had left at the time of the appointment. We do not know why he left or where he went. The coordinator went to F Wing to see Mr Blair, but he could not find him there either. He therefore left the prison without seeing Mr Blair.

40. That afternoon, the dual diagnosis worker told Mr Blair about her conversation with St Mungo's and that they had said his flat was secure while he was on remand. She noted that Mr Blair said that he felt better when he heard this.

Sunday 2 August

41. An officer said that he unlocked Mr Blair's cell on the morning of 2 August and Mr Blair had seemed happy at the time. At lunchtime, the officer said he heard a crashing sound from Mr Blair's cell. He went to investigate and found Mr Blair sweeping the floor of the cell. Mr Blair said he had accidentally knocked his chair over. The officer told us that he thought Mr Blair might have done this on purpose, as he was occasionally prone to small outbursts. He said that Mr Blair appeared calm and did not ask him about medication.

42. An officer, who was working on F1 landing (Mr Blair's landing) that afternoon, said that Mr Blair did not press his cell bell or call him to the cell that day. (We obtained cell bell records for F Wing for 2 August, which show Mr Blair did not press his cell bell at any time that day.) He said that the only time he saw Mr Blair on 2 August was at around 5.15pm, when he locked him in his cell, after he had collected his evening meal. He said that he did not speak to Mr Blair then or any other time that day

43. At around 5.45pm, an officer began to check the prisoners on the wing. He said Mr Blair was lying on the bottom bunk when he checked him and shouted, "Why don't you fuck off?" The officer said that Mr Blair continued to shout as he moved on to the next cell. He did not respond to Mr Blair, as he said it is not unusual for prisoners to be abusive at checks, as they do not like to be disturbed.

44. At around 7.30pm, an officer began another check of prisoners. When he looked through the observation panel of Mr Blair's cell he saw Mr Blair sitting naked on the floor of his cell, hanged from a ligature made from his shoelaces which he had tied to the bed frame. He shouted for help and asked someone to radio an emergency. He went into the cell and cut the laces from around Mr Blair's neck. Another officer radioed a medical emergency code and the control room called an ambulance. A nurse working on F Wing began cardiopulmonary resuscitation, assisted by the duty manager. The nurse attached a defibrillator, which found no shockable heart rhythm so the staff continued chest compressions. Paramedics arrived at Pentonville at 7.48pm and at Mr Blair's cell at 7.50pm. The paramedics took over emergency treatment, but, at 8.24pm, recorded that Mr Blair had died.

Contact with Mr Blair's family.

45. Mr Blair had not named a next of kin when he arrived at Pentonville, but the Head of Safer Prisons established from phone records that he had phoned his

parents and passed their number to the police who found the corresponding address. Because of the distance, she initially agreed with HMP Winchester that they would send a family liaison officer to inform his parents of Mr Blair's death. However, HMP Winchester then informed her that they were unable to help as their family liaison officer had delivered three deaths in custody notifications in a short period of time and did not have capacity to assist. She therefore asked the police to break the news instead.

46. A police officer went to Mr Blair's parents' home at around 3.00am on 3 August, but no one answered the door. The police told the Head of Safer Prisons that they had been unable to break the news. The police went back at around 8.30am and told Mr Blair's parents that he had died. A family liaison officer from Pentonville phoned Mr Blair's parents shortly afterwards and offered condolences and support. She spoke to Mr Blair's parents several times over the following days, although no one from the prison visited them. In line with Prison Service policy, the prison contributed to the costs of the funeral.

Support for prisoners and staff

47. After Mr Blair's death, the Head of Safer Prisons debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and offered her support and that of the staff care team. No one raised any immediate issues.

48. The prison posted notices informing other prisoners of Mr Blair's death, and offering support. Staff reviewed all prisoners assessed as a risk of suicide and self-harm, in case they had been adversely affected by Mr Blair's death.

Post-mortem report

49. A post-mortem examination established the cause of death as hanging.

Allegations from prisoners

50. After Mr Blair's death, three prisoners alleged that staff had behaved inappropriately to Mr Blair on 2 August. Two of the prisoners were in the cell next to Mr Blair, although one later withdrew his statement and said he was just repeating what his cellmate had told him had happened. The other prisoner was a landing cleaner.

51. The prisoner made the following allegations:

- Mr Blair was distressed and angry on 2 August, which he said was because healthcare staff had stopped his medication. He went to the treatment hatch but the nurse said his prescription had run out and he could not have any medication.
- At lunchtime, Mr Blair smashed up his cell and he heard him shouting things like, "Please leave me alone!" He called him to the window to talk, and Mr Blair said he did not have his medication and pleaded with him to help him get it.

- After lunch, he asked an officer to check Mr Blair, but the officer had said that Mr Blair was “attention seeking”.
- Shortly before tea, Mr Blair told an officer that he intended to kill himself. The officer had said, “I’m sick of you talking shit. If you want to do it, just get on with it and do it properly. And don’t make a mess as I don’t want to clean it up”.
- An officer unlocked Mr Blair for tea and, when she saw the mess in the cell, said, “You stupid man. What’s all this mess?” When Mr Blair said he had not got his medication, the officer told him he was just “attention seeking”.

52. Another prisoner said:

- Mr Blair was “going crazy” on 2 August, and wanted medication. He smashed up his cell and had been talking to himself.
- Before tea, an officer went to the cell and Mr Blair said that he needed medication. The officer had said, “Do it quickly, and don’t make a mess”.

Findings

Identifying risk of suicide and self-harm

53. Prison Service Instruction (PSI) 64/2011, which governs ACCT suicide and self-harm prevention procedures, requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures. We have considered whether staff at Pentonville should have recognised Mr Blair as at risk and begun ACCT procedures to support him.

54. When he arrived at Pentonville, Mr Blair had a number of risk factors for suicide. He had been under the care of mental health services in the community for many years and his escort record noted that he had schizophrenia. He was also withdrawing from alcohol. There is no indication that Mr Blair had harmed himself before, although he said at his initial health screen that he had thought about suicide in the past. A nurse did not ask him anything further about what had caused these thoughts and relied on Mr Blair saying that he no longer had suicidal thoughts.

55. PSI 7/2015, about early days in custody, has a mandatory action that reception staff must examine the person escort record (PER) and any other available documentation to identify any immediate needs or recorded risks. The nurse said that he did not see Mr Blair's PER and that he often does not see these documents or suicide and self-harm warning forms that court staff or police complete, if they are worried about a prisoner. Although Mr Blair's PER did not contain any information about risk other than his mental illness, which the nurse found out about when he spoke to Mr Blair, we are concerned as these documents often contain important information which reception nurses need to see to make a considered assessment about risk of suicide.

56. In a PPO thematic report about risk factors which increase the risk of suicide and self-harm, published in April 2014, we identified the risk factors that staff need to take into account when assessing the risk of suicide and self-harm. We also noted that people diagnosed with schizophrenia are twelve times more likely than others to kill themselves.

57. During his time at Pentonville, Mr Blair sometimes said he found it difficult to cope with withdrawing from alcohol. We have some concerns about how his withdrawal symptoms were assessed and that no one reviewed this medication or considered whether he should be prescribed the antidepressant he had taken in the community. (See clinical care section below.) An assistant psychologist and a dual diagnosis worker said that Mr Blair's main issue was that he was worried about losing his flat, and that he would have nowhere to live when he was released. None of the staff we spoke to had ever considered Mr Blair as at risk of suicide or self-harm and we accept that there was little to indicate that he was at heightened risk immediately before his death.

58. However, we are concerned about reception procedures. Although there is no compelling evidence that Mr Blair was obviously at raised risk of suicide when he first arrived at Pentonville, there is no record that any member of staff identified

or took into account his risk factors when assessing his risk of suicide. We are also concerned that not all reception staff routinely see and review key documents. We make the following recommendation:

The Governor should ensure that reception staff have a clear understanding of their responsibilities and the need to share all relevant information about risk, and that they consider and record all the known risk factors of a newly arrived prisoner when determining the risk of suicide and self-harm.

Clinical care

59. When he arrived at Pentonville, Mr Blair had not been prescribed antipsychotic medication for around three months. The clinical reviewer concluded that there was nothing in his presentation at Pentonville to suggest that he required antipsychotic medication.

60. Mr Blair had been prescribed an antidepressant in the community. Healthcare staff could not confirm this by contacting his GP, as they normally would, as Mr Blair was no longer registered. However, information sent to the prison by his community care coordinator and dual diagnosis worker confirmed that he was prescribed an antidepressant. There is no evidence that a prison GP or the mental health team multidisciplinary meeting reviewed this, as should have happened. The information from the community services was not scanned onto Mr Blair's medical record and Mr Blair did not receive any antidepressant medication while he was at Pentonville. We make the following recommendation:

The Head of Healthcare should ensure that a GP reviews prisoners' medication, when it is confirmed that they have been prescribed medication in the community.

61. Mr Blair sometimes said that he was struggling with symptoms of alcohol withdrawal, after he had finished the detoxification programme. Although this was recognised, there was no medication review and no one assessed Mr Blair's symptoms using a recognised alcohol withdrawal scale to check whether he needed additional medication or help to relieve withdrawal symptoms. We make the following recommendation:

The Head of Healthcare should ensure that clinical assessments of withdrawal symptoms are completed when prisoners who have finished an alcohol detoxification programme report difficulties with ongoing symptoms.

Allegations from prisoners

62. Three prisoners made allegations about events they had witnessed on the day Mr Blair died, although one later retracted his statement. The allegations were that Mr Blair had been refused medication at the treatment hatch, smashed up his cell and spent much of the day calling officers to the cell to ask for medication. The prisoners said that prison officers did not take Mr Blair seriously and made inappropriate, abusive comments to him and encouraged him to kill himself.

63. We spoke to the officers named by the prisoners, all of whom said they had little or no contact with Mr Blair that day and that the prisoners' allegations were not true. Unfortunately, there is no closed circuit television coverage on F Wing, so we have been unable to check these accounts. None of the staff, including others we spoke to who, said they saw any sign of disturbance or damage to the cell, except that an officer said he found Mr Blair clearing up his cell after what appeared to be a relatively minor incident.

64. Mr Blair had not been prescribed medication for several weeks. A pharmacy technician, who was working at the F Wing treatment hatch on 2 August, said that Mr Blair did not come to the hatch to ask for medication at any time that day. The prisoners said that Mr Blair had used his cell bell numerous times to call officers to the cell, but there are electronic records of all cell bell usage and these records show that Mr Blair did not use his cell bell at all that day.

65. The prisoners also alleged that no one tried to resuscitate Mr Blair until paramedics arrived. However, the ambulance service records state that an officer and nurse were administering cardiopulmonary resuscitation when they got to the cell.

66. While the prisoners' accounts were broadly consistent, one of the prisoners said he had simply repeated what his cellmate had told him and later retracted his statement. The documentary evidence of the cell bell and ambulance records contradicts the prisoners' accounts. Without independent corroboration, it is not possible to know exactly what happened.

Family liaison

67. Prison Rule 22 requires prisons to inform the next of kin immediately if a prisoner dies or is seriously ill. PSI 64/2011 states that, wherever possible, a family liaison officer and another member of prison staff must visit a prisoner's family in person to break the news of a death. Where the prisoner is located a long distance from their family it states that prisons should consider asking for help from a family liaison officer at a prison near to the family.

68. The duty governor initially asked HMP Winchester to send a family liaison officer to break the news to Mr Blair's parents. They initially agreed to do this but later said they could not help, as their family liaison officer did not have capacity to assist. She therefore asked the police to visit. They were unsuccessful when they visited Mr Blair's parents at 3.00am, but returned at 8.30am to break the news of the death.

69. Although we appreciate the difficulties of visiting an unknown area late at night, national instructions are clear that, wherever possible, a prison family liaison officer must visit the next of kin in person to break the news of the death. Once the police had told Pentonville that they would go back to Mr Blair's parents' house in the morning, it should have been possible for staff from Pentonville to have travelled there to break the news in person and explain what had happened. We make the following recommendation:

The Governor should ensure that, where possible, a member of Prison Service staff informs a prisoner's family quickly and in person of their death, in line with national instructions.

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