Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Robert Gardener, a prisoner at HMP Hewell, on 28 April 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 Robert Gardener was found hanged in his cell at HMP Hewell on 28 April 2015. He was 43 years old. I offer my condolences to Mr Gardener's family and friends.

A nurse appropriately identified Mr Gardener's risk and began suicide and self-harm prevention procedures when he first arrived at Hewell on 10 March. However, the investigation found a number of serious deficiencies in the operation of these procedures, which the prison will need to address. Despite being referred twice, no one from the mental health team assessed Mr Gardener and I am concerned that there was little evidence of effective engagement with Mr Gardener after 2 April, when staff stopped suicide and self-harm monitoring.

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 **December 2015**

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Summary

Events

1. On 10 March 2015, Mr Robert Gardener was remanded to HMP Hewell charged with sexual assault. He was next due to appear at court on 16 June. Mr Gardener had served three previous prison sentences, the last ending in 2012. He had a history of drug and alcohol misuse.

2. When he arrived at Hewell, a nurse began Prison Service suicide and self-harm prevention procedures (known as ACCT) when Mr Gardener said that he had recently attempted suicide by taking an overdose. On 18 March, Mr Gardener harmed himself by cutting his stomach. On 2 April, staff ended ACCT monitoring when Mr Gardener said he felt settled.

3. At 4.24am on 28 April, a night patrol officer found Mr Gardener hanged in his cell. Staff attempted to resuscitate Mr Gardener until paramedics arrived and took over emergency treatment. At 5.26am, the paramedics confirmed that Mr Gardener had died.

Findings

4. The decision to open an ACCT when Mr Gardener arrived was appropriate. However, we found that staff at Hewell did not complete ACCT procedures correctly. They did not hold an immediate case review after Mr Gardener had self-harmed on 18 March. None of the case reviews were multidisciplinary and the frequency of observations was not correctly documented. Staff at case reviews did not consider all Mr Gardener's risk factors when assessing his risk of suicide and self-harm and set caremap actions that were little more than referrals to services. Because of this, the ACCT was closed without any firm evidence that Mr Gardener's risk of suicide and self-harm had reduced.

5. We were also concerned that two referrals to the mental health team were not actioned and Mr Gardener did not receive any support from the mental health team. There was no recorded contact between officers and Mr Gardener after 2 April, when staff closed the ACCT.

Recommendations

- The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines. In particular:

    - Case reviews should be multidisciplinary, attended by all relevant people involved in a prisoner's care and assess the level of risk taking into account all risk factors.
    - Levels of observations should reflect the risk, should be adjusted when risk changes and staff should carry out and record all required observations as soon as possible after they are made.
    - Case managers should set caremap actions which are specific and meaningful and should review progress against caremaps at each review.

    - ACCTs should not be closed until the risk has reduced and all caremap actions have been completed.

- The Governor should ensure that officers have meaningful contact with every prisoner, through an effective personal officer scheme which ensures that officers get to know prisoners and identify their needs backed up by regular case history notes.

- The Head of Healthcare should ensure that referrals to the mental health team are actioned promptly and managed effectively.

The Investigation Process

6. The investigator issued notices to staff and prisoners at HMP Hewell informing them of the investigation and asking anyone with relevant information to contact him. One prisoner responded.

7. The investigator visited Hewell on 30 April. He obtained copies of relevant extracts from Mr Gardener's prison and medical records.

8. NHS England commissioned a clinical reviewer to review Mr Gardener's clinical care at the prison.

9. The investigator interviewed 12 members of staff and one prisoner at Hewell in May and June, two jointly with the clinical reviewer.

10. We informed HM Coroner for Worcestershire of the investigation, who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

11. One of the Ombudsman's family liaison officers contacted Mr Gardener's family, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Mr Gardener's family wanted to know why he had not received treatment for depression and alcohol and drug addiction, and why the prison had ended suicide prevention procedures. Mr Gardener's family received a copy of the initial report. They raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence. The Prison Service has provided an action plan to address the recommendations made in this report.

Background Information

HMP Hewell

12. HMP Hewell is an amalgamation of two prisons, the former HMP Blakenhurst, and HMP Hewell Grange. The Hewell Grange site continues to operate as an open prison and the Blakenhurst site is a secure, local prison. Mr Gardener was at the Blakenhurst site which comprises six houseblocks, holding around 1100 men. Health services are provided by Worcestershire Health and Care NHS Trust.

HM Inspectorate of Prisons

13. The most recent inspection of Hewell was in July 2014. Inspectors found that ACCT case reviews were often not multidisciplinary and healthcare staff had not attended any of the reviews they examined. Inspectors noted that many triggers for suicide and self-harm recorded in ACCT documents focused on past rather than future events that could prompt suicide or self-harm. Relationships between prisoners and staff were generally good but inspectors found that the personal officer scheme did not work effectively and many prisoners said they did not have a personal officer. Progress on implementing PPO recommendations from investigation into deaths at the prison had been slow. Prisoners did not have good access to healthcare appointments, especially to see a GP. There was a high level of non-attendance at healthcare appointments, partially due to a shortage of prison staff to escort prisoners. Inspectors found mental health services were adequate, but prisoners had no access to professional counselling.

Independent Monitoring Board

14. 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 2013-2014 annual report, the IMB noted that, in recent years, there had been a significant increase in incidents of self-harm and bullying. They reported that staff were more vigilant, with increased numbers of prisoners supported for risk of suicide and self-harm.

Previous deaths at HMP Hull

15. Since 2013, we have investigated six previous self-inflicted deaths at Hewell. (There has been a further apparent self-inflicted death since.) We have made previous recommendations about ACCT procedures and the lack of personal officer contact, issues we have identified again in this investigation.

Assessment, Care in Custody and Teamwork

16. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the

prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

17. On 10 March 2015, Mr Robert Gardener was remanded to HMP Hewell, charged with sexual assault. His next court appearance was scheduled for 16 June. Mr Gardener had served three previous prison sentences and had been released from the most recent in 2012. There is no record that he had been regarded as at risk of suicide and self-harm during previous prison sentences. He had a history of drug and alcohol misuse.

18. When he arrived at Hewell, Mr Gardener told a nurse at an initial health screen that he had tried to kill himself two weeks earlier by taking an overdose of paracetamol when he was under the influence of drugs and alcohol. He said he still had thoughts of suicide but had not formulated plans. The nurse immediately began ACCT procedures.

19. The nurse recorded in Mr Gardener's medical record that he had reported using drugs (usually cocaine) and drank an average of twenty units of alcohol a day. (The NHS recommended maximum intake is 3-4 units.) The nurse noted that Mr Gardener showed no visible signs of withdrawal. Mr Gardener gave details of his community GP and the nurse referred him to the doctor, the substance misuse team and the mental health team.

20. A Supervising Officer (SO) completed an ACCT immediate action plan and Mr Gardener said that he knew how to access the Samaritans and Listeners (prisoners trained by the Samaritans to support other prisoners). The SO assessed Mr Gardener as at raised risk of suicide and self-harm and noted that staff should check him at least once an hour.

21. At 9.40am on 11 March, an officer assessed Mr Gardener as part of ACCT procedures. Mr Gardener said that he felt unstable and was finding it difficult to cope with the breakdown of a relationship. He said he had a history of alcohol and drug abuse and had taken an overdose two weeks earlier, as he had nothing to live for. He said he had taken two overdoses in 2012 and still had thoughts of suicide. He told the officer that he was a solitary person who liked his own space. He said that his daughter would visit him but he did not want his grandson to see him in prison.

22. An officer told Mr Gardener about the help he could get for his addiction and mental health problems. Mr Gardener said that he had been in Hewell before and was aware of the services available. The officer recorded that Mr Gardener had agreed that the ACCT should remain open and that he would seek help for his addiction and mental health problems.

23. On 11 March, Mr Gardener did not attend scheduled appointments with the substance misuse team and a nurse. No reasons were recorded. The GP details Mr Gardener had given for his GP were inaccurate and a healthcare clerical support worker could find no record of him in community patient registers.

24. At 11.00am, a Supervising Officer (SO) and an officer held the first ACCT case review with Mr Gardener. No healthcare staff were present and no staff from any other discipline. The SO recorded that Mr Gardener was in a low mood and had a history of suicide attempts. Mr Gardener said that he felt anxious about his trial

and preferred not to mix with other prisoners. The SO recorded that Mr Gardener was at low risk of suicide and self-harm, but kept the level of observations at hourly. The SO entered three actions on the ACCT caremap: for Mr Gardener to see the substance misuse team; to see the mental health team; and to see the housing association (which made frequent visits to Hewell) about his accommodation and rent. The next case review was set for 13 March.

25. That afternoon, a prison GP saw Mr Gardener, who said that he felt worthless and hopeless and had felt that way for a long time. He said he had mental health problems and had previously received counselling and medication. Mr Gardener said that he had been prescribed fluoxetine (an antidepressant) and other medications in the past, but now did not want to take any medication. He said he had taken an overdose of 64 paracetamol tablets two weeks before but had not sought any treatment. He told the doctor that he would have killed himself, if he had been released from court. He reported using cocaine and that he drank one and a half bottles of vodka a day.

26. The GP recorded that Mr Gardener showed no physical signs of withdrawal, or acute liver failure and no clinical signs of illness. She arranged urgent blood tests. She noted that Mr Gardener should remain on an ACCT with hourly observations. If his mood deteriorated, she recommended that he should be constantly supervised.

27. On 12 March, Mr Gardener did not attend a second health screen. He saw a substance misuse nurse that day, but did not want to engage with service. He signed a disclaimer to confirm that he had declined any clinical treatment for substance misuse.

28. On 13 March, a prison GP reviewed Mr Gardener's blood test results, which were normal except that liver function tests were slightly raised. She said she would have expected this result in a patient who said he drank excessive amounts of alcohol, but the result did not indicate that any urgent treatment was required.

29. That afternoon, a nurse saw Mr Gardener for a second health screen and noted that he had a history of depression but had stopped taking medication. Mr Gardener said that he had been detained under the Mental Health Act for three months in 2012. (This was confirmed from community records after his death.) No one from the mental health team had assessed Mr Gardener since the referral from reception and the nurse referred Mr Gardener again. (No one from the mental health team saw Mr Gardener before he died.)

30. At 3.40pm, a SO and an officer held an ACCT case review. The SO recorded that he had received verbal input from a member of the healthcare team that Mr Gardener was not on any medication, had been seen by the substance misuse team and would be followed up again, but had not had a mental health assessment. Mr Gardener said that he was due to have a visit from his daughter the next day. He said he did not enjoy living but had no current thoughts of suicide or self-harm. The SO considered that his level of risk of suicide and self-harm remained low and reduced the level of observations to every two hours during the day and hourly at night. The SO updated the caremap that the action for the substance misuse team was closed. He set the next review for 16 March.

31. On 16 March, the SO held an ACCT review on his own with Mr Gardener. He recorded that there had been no change, the level of risk remained low and the level of observations remained the same. He arranged the next review for 23 March.

32. On 18 March, at 9.15pm, a night patrol officer responded to Mr Gardener's cell bell and found that Mr Gardener had made some cuts to his stomach. He radioed for emergency medical help. A nurse responded and recorded that the cuts were superficial and approximately two to three inches long. She treated them with steristrips and dressings. Mr Gardener said he did not want to see a member of the mental health team.

33. The custodial manager in charge of the operation of the prison that night decided that the level of observations should remain hourly throughout the night. He recorded this in the ACCT document. He told the investigator that he had not seen or read Mr Gardener's ACCT document. He said that he was aware that the national instructions required an urgent ACCT case review when there had been an incident of self-harm, but said he did not consider this was necessary as the cuts were superficial and he did not have time to conduct ACCT reviews at night. He did not arrange an ACCT review for the next morning to reassess Mr Gardener's risk.

34. The officer working nights on Mr Gardener's houseblock between 20 to 23 March recorded in the ACCT document that he had observed Mr Gardener every two, three or four hours, not hourly as required. Of the 18 checks he recorded over the four nights, 15 were exactly on the hour and the other three were on the half hour. He said that he had carried out checks every hour at irregular times, but did not record each individual check. (There is no CCTV on the houseblock, so we have been unable to check this.)

35. At 6.00pm on 23 March, a SO held another ACCT review with Mr Gardener without any other member of staff present or any briefing from healthcare staff. The SO recorded that Mr Gardener had seen the housing association and that all the actions on the caremap were closed. (Other than on the ACCT document, there is no record that anyone from the housing association saw Mr Gardener.) The SO decided that the ACCT should remain open, as Mr Gardener had self-harmed four days earlier. Mr Gardener said he had cut himself out of frustration, as his daughter had been unable to book a visit. The SO assessed that the level of risk was low and the kept the level of observations at every two hours during the day and hourly at night. He set the next review for 30 March, but this did not take place.

36. On 2 April, a custodial manager and an officer held an ACCT review. There is no record why the review originally scheduled for 30 March did not take place. The manager noted that Mr Gardener's daughter had visited him and he felt comfortable and settled. He recorded that no one from the healthcare team had been available to give any input but had said that Mr Gardener was not on medication or under the care of the mental health team. They agreed that Mr Gardener's risk of suicide and self-harm was low and decided to close the ACCT. They set a post-closure review for 9 April.

37. The custodial manager told the investigator that had Mr Gardener been under the care of the mental health team he would not have closed the ACCT without their input and agreement. He was not aware that, despite two referrals, no one from the mental health team had assessed Mr Gardener.

38. On 13 April (not 9 April as arranged), a SO, who had not met Mr Gardner before, interviewed him for an ACCT post-closure review. Mr Gardener said that he was calm and had no issues. He said he received support from his daughter and would talk to another SO if he had any problems. Mr Gardener said that if he were sentenced, he would apply to be a Listener, as he had been one before at Hewell. (Post-closure interviews should usually be done within seven day of the ACCT being closed. The SO told the investigator that she did not usually work on Mr Gardener's houseblock, but had been asked to work there on 13 April. She had decided to hold the post-closure review when she noticed it had not been done.)

39. Mr Gardener phoned his daughter frequently and last spoke to her shortly after 5.00pm on 27 April, for just under three minutes. For security purposes all calls, apart from legally privileged calls, are recorded and the investigator listened to the call. Mr Gardener asked about his family and his daughter told him that a family member did not want to see him again. The call ended with them saying, "See you soon" to each other.

40. The only entries in Mr Gardener's prison record case notes show when the ACCT was opened and closed and that he had completed his induction programme. After the custodial manager wrote in Mr Gardener's record on 2 April to note the ACCT was closed, there were no other entries by any member of staff.

41. Early on 28 April, a night patrol officer was checking that all prisoners were present in their cells. When he arrived at Mr Gardener's cell, at 4.24am, he looked through the door observation panel and saw Mr Gardener in what appeared to be an unnatural sitting position with nylon cord, tied around his neck attached to the cupboard. He immediately radioed a code blue medical emergency (which indicated a life-threatening situation such as when a prisoner is unconscious or not breathing). For security reasons, prison staff in residential areas do not carry standard prison keys but have a cell key in a sealed pouch for use in emergencies. He broke the seal and used the emergency key to go into the cell. He cut the cord from around Mr Gardener's neck and lowered him to the floor. Within seconds, another night patrol officer joined him and they began cardiopulmonary resuscitation. The communications log shows that control room staff called an ambulance immediately they received the code blue call at 4.24am.

42. Other staff, including a nurse, responded quickly. They continued to attempt resuscitation and used an automated external defibrillator (which monitors the heart rhythm and administers electrical shocks to restore the normal rhythm when necessary). The defibrillator found no shockable rhythm. At 4.50am, paramedics arrived at the cell and took over the emergency treatment. At 5.26am, the paramedics confirmed that Mr Gardener had died.

Contact with Mr Gardener's family.

43. The deputy governor and a prison chaplain visited Mr Gardener's daughter at home that morning to break the news that her father had died and offer condolences. A prison family liaison officer supported her subsequently. In line with Prison Service instructions, the prison contributed to the costs of the funeral.

Support for prisoners and staff

44. After Mr Gardener's death a custodial manager debriefed the staff involved in the emergency to allow them to discuss any issues arising, and to offer his support and that of the staff care team.

45. The prison posted notices informing other prisoners of Mr Gardener's death, and offering support. Staff reviewed all prisoners subject to suicide and self-harm prevention procedures in case they had been adversely affected by Mr Gardener's death.

Post-mortem report

46. A post-mortem examination found that the cause of death was hanging. There was no evidence of any drug use.

Findings

Management of risk of suicide and self harm

47. A nurse appropriately opened an ACCT on 10 March, after Mr Gardener said he had tried to kill himself by overdose, two weeks earlier. A SO assessed Mr Gardener as at raised risk of suicide and self-harm and set the level of observations at hourly. We consider the initial level of observations of hourly appears relatively low for someone considered at raised risk of suicide.

48. Prison Service Instruction (PSI) 64/2011, which covers ACCT procedures, has a mandatory instruction that staff must follow the level of observations and conversations as stated in the 'required frequency of conversations and observations' box on the front cover of the ACCT and that the observations must be recorded immediately or as soon as practicable thereafter. Other checks were recorded as required, but on the nights of 20- 23 March, an officer recorded only 18 checks out of 40, which should have been done. Some were as far apart as four hours, when they should have been hourly. Even if the officer completed checks without recording them, this would not comply with the national instruction.

49. PSI 64/2011 requires ACCT case reviews to be multidisciplinary where possible. We are concerned that none of the case reviews was multidisciplinary. In particular, there was no healthcare representative at the initial case review when the ACCT was opened, which is a mandatory requirement of PSI 64/2011. Two case reviews had just one member of staff present, which is entirely inappropriate. Whether or not reviews are multi-disciplinary, it is implicit that ACCT reviews, which are based on teamwork, are not held by just one member of staff. These are matters we have raised with Hewell before.

50. PSI 64/2011 also contains instructions that "In addition to planned case reviews, where an ACCT trigger is activated i.e. the event actually occurs or there are other concerns such as increases in frequency or lethality e.g. from cutting or using ligatures, a case review must be held". We recognise that it might have been difficult for a custodial manager to hold a formal ACCT review during the night (although we have seen this happen in other prisons). However, we are concerned that he did not consult the ACCT document when reviewing his level of risk or schedule an ACCT review for the morning, when more staff would have been available.

51. We do not consider that the assessed level of risk and the level of required observations reflected Mr Gardener's actual risk after he cut himself on 18 March. On 23 March, a SO assessed Mr Gardener's risk of further self-harm as low, despite his very recent act of self-harm. He left the level of observation unchanged.

52. The caremap objectives set at the ACCT review on 11 March amounted to no more than referrals to services. These actions were insufficient in themselves to help reduce Mr Gardener's risk or ensure that his identified issues were addressed. The actions - a referral to the substance misuse team, a referral to the mental health team and a referral to the housing association - were marked as completed before there had been any meaningful intervention. The referral to the mental health team was never progressed. Despite this, at an ACCT case

review on 2 April, with no healthcare input, the SO marked the caremap objectives as completed.

53. PSI 64/2011 states that caremap actions should have detailed, time-bound actions aimed at reducing the prisoners risk While an essential first step, it is difficult to see how a caremap action simply to refer someone for an assessment will reduce their risk. ACCT case reviews should have discussed the outcome of the referrals and the ACCT should not have been closed until all caremap actions had been completed.

54. In a thematic report about risk factors in self-inflicted deaths published in April 2014, we noted that assessments of risk too often placed insufficient weight on known risk factors and too much on staff perceptions of the prisoner's behaviour and demeanour. Mr Gardener had a number of factors known to increase the risk of suicide and self-harm which are identified in our thematic report and in Prison Service instructions: he had a recent suicide attempt, he had recently self-harmed and he had reported mental health problems. The clinical reviewer noted that Mr Gardener had a diagnosis of borderline personality disorder, which increases the risk of suicide. She considered it was therefore likely that Mr Gardener would attempt suicide again at some point and the assessments of low risk of suicide, did not take into account the historical evidence about his risk of repeated self-harm.

55. Mr Gardener was managed under ACCT procedures for just a short time. However, case reviews were not multidisciplinary, an urgent case review was not conducted, the observations were not completed and recorded properly, and we consider that the ACCT was closed prematurely, before Mr Gardener had received proper support. We make the following recommendation:

The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines. In particular:

- **Case reviews should be multidisciplinary, attended by all relevant people involved in a prisoner's care and assess the level of risk taking into account all risk factors.**
- **Levels of observations should reflect the risk, should be adjusted when risk changes and staff should carry out and record all required observations as soon as possible after they are made.**
- **Case managers should set caremap actions which are specific and meaningful and should review progress against caremaps at each review.**
- **ACCTs should not be closed until the risk has reduced and all caremap actions have been completed.**

Personal Officer Scheme

56. Personal officers are allocated a specific number of cells at Hewell so that each officer is responsible for 12 prisoners. They are expected to talk to the prisoners they are responsible for, get to know them and make weekly entries in their prison case notes.

57. From 2 April, when the ACCT was closed, until 28 April, when Mr Gardener died, no member of staff made any entries in Mr Gardener's case notes in his prison record. There is no record of a personal officer introduction and no record of any management checks that would have identified that Mr Gardener did not have contact with a personal officer or the lack of entries in his record.

58. At the last inspection of Hewell, HM Inspectorate of Prisons found that the personal officer scheme did not operate effectively and significantly fewer prisoners in their survey than in comparator prisons said they had a personal officer. We have made recommendations about personal officers in two previous investigation reports into deaths at Hewell. There was little evidence that any of the staff really knew Mr Gardener or anything about his background, or were able to offer him meaningful support. We repeat our previous recommendation:

The Governor should ensure that officers have meaningful contact with every prisoner, through an effective personal officer scheme which ensures that officers get to know prisoners and identify their needs backed up by regular case history notes.

Clinical Care

59. A nurse in reception referred Mr Gardener to the mental health team and, two days later, the nurse who carried out a secondary health screen made another referral. The mental health team did not take any action as a result of these referrals. When asked if he wanted to see a mental health nurse after the episode of self-harm, Mr Gardener declined but no one followed this up, despite his actions.

60. The clinical reviewer considered that it was impossible to know whether Mr Gardener's decision to take his own life on 28 April was a planned or an impulsive act. However, she was concerned that there was no involvement with the mental health team and several opportunities to engage Mr Gardener were missed. The episode of self-harm on 18 March should have triggered further efforts to involve the mental health team. The lack of healthcare staff involvement in ACCT reviews, and the closure of the ACCT before a member of the mental health team had seen Mr Gardener, contributed to the difficulty.

61. Referrals to the mental health team, and other health services, are made through SystmOne, the computerised medical record system used in prisons. The healthcare manager told the investigator and clinical reviewer that the failure of the second referral was because of a system error. We would expect all prisoners who are assessed as at risk of suicide and self-harm to have a prompt mental health assessment. This was all the more important for Mr Gardener, because of his recent suicide attempt and psychiatric history. Because of the failure to assess Mr Gardener's mental health, the clinical reviewer did not consider that the standard of care Mr Gardener received at Hewell was equivalent to the care he could have expected to receive in the community. We make the following recommendation:

The Head of Healthcare should ensure that referrals to the mental health team are actioned promptly and managed effectively.

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