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A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

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**Investigation into the death of a man in October 2013  
at HMP Blundeston**

## ***Our Vision***

*'To be a leading, independent investigatory body,  
a model to others, that makes a significant contribution to  
safer, fairer custody and offender supervision'*

This is the investigation report into the death of a man in October 2013, at HMP Blundeston. The man was 40 years old and died from hypovolaemic shock, a condition in which severe blood and fluid loss makes the heart unable to pump enough blood around the body. I offer my condolences to the man's family and friends.

An investigator was appointed and a clinical reviewer conducted a review of the man's clinical care. HMP Blundeston cooperated fully with the investigation.

The man had a history of substance misuse problems and back pain for which he was prescribed medication. He also had problems sleeping for which he was sometimes prescribed zopiclone. As zopiclone is not recommended for long-term use, doctors attempted to reduce his reliance on it, but the man self-harmed several times by cutting himself when zopiclone was withdrawn.

On 4 October 2013, the man was taken to hospital as he had cut his arm and lost a significant amount of blood. He refused to have the blood transfusion he needed and was taken back to the prison. Prison staff do not appear to have had clear instructions from the hospital about how to manage the man and hospital staff assumed he would be brought back to hospital if he began to bleed again. There were no healthcare staff at the prison at night, so the man was kept under observation in the segregation unit. Shortly after he returned, he opened up his wound and began to bleed, but not profusely. He asked to be taken back to hospital, but the officer in charge of the prison that night did not consider this necessary, nor did he seek medical advice or consult the on-call duty governor. The man continued to be observed, but officers did not recognise that his symptoms were worrying and did not ask for further advice. At 6.00am, the man became unresponsive and could not be resuscitated.

The investigation has identified a large number of deficiencies in the man's care at HMP Blundeston. While the man appears to have been a complex and difficult person to manage, the prison's suicide and self-harm prevention procedures did not operate well to protect him. In addition, there was no effective primary mental health service and a lack of integrated management of the challenges he presented. There was inexcusable delay in taking the man to hospital when he cut himself on the evening of 4 October, resulting in a significant loss of blood. While the man chose to refuse treatment when he went to hospital, prison staff seem to have been unaware of the risk that he might die. I consider they should have taken him back to hospital when he began to bleed again or at the very least sought urgent medical advice. Had they done so, it is possible that the man's death might have been avoided. As the prison has now closed, I make no recommendations for improvement.

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.

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

**September 2014**

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## SUMMARY

1. The man was released from prison on licence on 12 September 2012, but recalled to custody two days later. He had a long history of drug addiction for which he was prescribed methadone. He was also prescribed strong painkillers for a back injury. He suffered from insomnia and seemed to have developed a reliance on zopiclone, to help him sleep. The long-term use of zopiclone is not advised and doctors tried to persuade him to use alternative treatments. In March 2013, the man began to self-harm by cutting himself. He appeared to use self-harm to help him cope and to get the medication he wanted- particularly zopiclone.
2. On 2 October 2013, the man cut his arm with a razor blade and suicide and self-harm prevention procedures, known as ACCT, began. Some blood was coming from an artery, but he had to be persuaded to go to hospital and the prison GP gave him diazepam to help him cope with anxiety. He told the doctor in the hospital accident and emergency department that he had cut himself because he could not cope with his back pain. He would not agree to have his wound stitched, but had it glued and steri-stripped. The doctor gave him a box of 14 diazepam tablets. The man was not allowed to keep his own medication at the prison, but no one removed it from him when he returned and there were no healthcare staff on duty. The next day, 3 October, the box of diazepam was empty. The same day, a manager closed the man's ACCT as he did not consider he was at risk of further self-harm.
3. On Friday 4 October, a two week prescription of zopiclone ended. The man was upset and threatened to cut himself in order to get to hospital. His threat was taken seriously and the ACCT was reopened. The healthcare manager prepared a letter in case the man was taken to hospital indicating that he should not be given any further medication to bring back to the prison.
4. At 6.20pm on 4 October, the man cut himself and lost a significant amount of blood. An emergency ambulance was not called immediately as it should have been. Instead, the manager in charge of the prison sought advice from the NHS 111 service which indicated the man should go to hospital. In the meantime, the man had lost a lot more blood. An emergency ambulance was requested at 7.02pm, 40 minutes after the man had first been seen bleeding heavily. The prison did not make the urgency of the situation clear, so the ambulance service did not give the call the highest priority. This meant that ambulance staff did not arrive reach the man until 7.50 pm, two and a half hours after the emergency incident.
5. Paramedics were concerned about the amount of blood the man had lost and believed he was in danger of hypovolaemic shock. As escort staff were not ready, there was a further unacceptable delay of 18 minutes before the ambulance was able to leave the prison.
6. At hospital, a doctor declined to give the man medication to relieve his anxiety, partly influenced by the letter from the prison. The doctor said the man needed a blood transfusion, but he refused any treatment. As he

continued to refuse treatment, there was nothing the hospital could do and he was taken back to the prison. The hospital doctor did not consider that the man was in danger of hypovolaemic shock at that time, but thought that any further blood loss might put him in danger.

7. The hospital staff did not give the escorting prison staff any formal discharge instructions or tell them of any symptoms or signs to be alert for. As a result, prison staff did not appear to understand that any further blood loss should result in the man being brought back to hospital. The hospital doctor believed that he had explained the risks to the man and that it was common sense that if the man cut himself or began to bleed again, he should be brought back to hospital.
8. When he returned to Blundeston, the man was held in the segregation unit so he could be observed. No one contacted the duty governor about the events of the night or to get her agreement to locate the man in the segregation unit as should have happened.
9. Shortly after he returned to the prison, the man opened up the wound in his arm and asked to be taken back to hospital. The night orderly officer decided there was no need, but did not seek any medical advice or consult the duty governor. The man fell asleep until 3.00am and from that time was awake and demanding tobacco, medication and to go back to hospital. Staff gave him extra blankets and water at 3.30am. He then became incontinent and unable to stand up without becoming lightheaded and unsteady on his feet. From 5.00am onwards, the man asked for oxygen and was shouting that he could not cope. The two staff in the segregation unit did not discuss whether the man should go back to hospital, seek medical advice or contact the night orderly officer. They were not aware of the symptoms of hypovolaemic shock or that the man was in danger of it.
10. Shortly after 6.00am, the segregation unit officer found the man unresponsive. He did not call an emergency code as he should have done so an ambulance was not called immediately. Prison staff and paramedics tried to resuscitate the man, but without success.
11. The man never received a full mental health assessment and the clinical reviewer found that the lack of primary mental health support indicated that the man's care at the prison was not equivalent to what he could have expected to receive in the community. Our investigation found a number of deficiencies in relation to the management of the man's self-harm, ACCT procedures, communication with the hospital and ongoing monitoring and care. There were unacceptable delays in taking the man to hospital on 4 October and a failure to seek medical advice or take the man back to hospital in the early hours of 5 October when he began to bleed again.

## THE INVESTIGATION PROCESS

12. The investigator issued notices to staff and prisoners at Blundeston informing them of the investigation and inviting anyone with relevant information to contact her.
13. The investigator visited Blundeston on 11 October and went to D wing and the segregation unit. She met senior managers and collected relevant documents about the man's time in custody. The investigator also met the police. In November, she interviewed 16 members of staff and five prisoners. She gave preliminary feedback about the investigation's initial findings to the Governor.
14. NHS England commissioned a clinical reviewer to review the man's clinical care and was involved in many of the interviews with the investigator. The clinical reviewer and the investigator interviewed three members of medical staff from the Accident and Emergency Department at the James Paget Hospital. The clinical reviewer also obtained further specialist opinions from two doctors.
15. We informed HM Coroner for Suffolk and South East Essex of the investigation. The Coroner provided the results of the post-mortem examination and toxicology report.
16. One of the Ombudsman's family liaison officers contacted the man's family to let them know about the investigation and invited them to identify issues they wished the investigation to consider. The investigator and family liaison officer met the man's family and their legal representatives later and answered many of the man's family's questions. The man's family wanted to know:
  - Was the man bullied?
  - How was he able to obtain a sharp instrument to cut himself?
  - Did he have a history of self harming?
  - Why was he not given the medication he needed?
17. We found no evidence that the man was being bullied. We discuss the other issues in the report.
18. The man's family received a copy of the draft report. The solicitor representing the man's family wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

## **HMP BLUNDESTON**

19. HMP Blundeston was a category C prison near Lowestoft in Suffolk which held up to 526 men. The prison closed in December 2013. At the time of the man's death, some wings were already empty. The man lived on D wing which did not have in-cell sanitation. Instead, there was an electronic unlock system which allowed one prisoner at a time out of their cell to use the toilet. D wing was the Integrated Drug and Treatment Services (IDTS) unit, providing clinical and psychosocial services for men with substance use problems.
20. East Coast Community Healthcare (ECCH) provided health services. There was no separate primary mental health service. Norfolk and Suffolk Foundation Trust (NSFT) ran an in-reach service for men with severe and enduring mental health problems.

## **HM Inspectorate of Prisons**

21. HM Inspectorate of Prison's (HMIP) last inspection of Blundeston in April 2013 found that in most areas the prison had improved since the previous inspection two years earlier. However, inspectors described healthcare provision as very poor. They had significant concerns about prescribing practice, which they considered impacted on the overall safety of the prison. There was almost no primary mental health care, despite high need. HMIP raised these concerns with NHS England which, from April 2013, took over responsibility for commissioning offender health. The Care Quality Commission (CQC) accompanied HMIP on the inspection and issued three enforcement warning notices.
22. Inspectors noted that the level of self-harm was low and that few prisoners were monitored under suicide and self-harm prevention procedures (known as ACCT). While prisoners were positive about their care, the quality of ACCT documents was generally inadequate. There was a high use of segregation. Inspectors were concerned that the consequences of a smoking ban for prisoners in the segregation unit had not been fully considered.

## **Independent Monitoring Board**

23. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure that prisoners are treated fairly and decently. In its final report (from June 2012 to January 2014), the IMB was critical of the decision to close the prison. They said that ACCT documents were of a good standard and that prisoners at risk were well supported. The IMB regarded HMIP criticism of healthcare provision as unhelpful to the morale of healthcare staff, many of whom were not aware of the reasons for the criticism. The IMB noted that a primary mental health service had been introduced in November 2013, six weeks before the prison was due to close, which the IMB assumed was because the healthcare provider had to comply with an enforcement notice issued by the CQC.

## **Previous deaths at Blundeston**

24. There had been no previous deaths at Blundeston since the Ombudsman began investigating deaths in custody in 2004.

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

25. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. The purpose of the ACCT 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. Checks should not be at predictable intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all the actions of the caremap have been completed.

## **KEY EVENTS**

26. The man was sentenced to three years in prison on 26 September 2011 after being convicted of grievous bodily harm. Throughout his sentence, the man received medication including methadone (a heroin substitute), gabapentin, tramadol (both pain killers), benzodiazepines and zopiclone (for anxiety and insomnia). The man admitted to taking additional illicit medication. He reported no mental health problems during this period.
27. The man was released on licence on 12 September 2012. However, his licence was revoked two days later after he had tested positive for drugs and was charged with further offences while drunk. The man was taken to HMP Liverpool on 17 September 2012. His revised release date was 16 March 2014.
28. The man told the reception nurse at Liverpool that he had mental health problems. He said he heard a voice in his head, felt depressed on occasions and had a tendency towards obsessive compulsive disorder. A mental health nurse saw the man on 26 September. However, the man denied ever saying he had any mental health issues and did not want any mental health input.
29. On 23 November 2012, the man transferred to HMP Onley. At reception, he said he had received some bad news and needed help to sleep. The GP prescribed three days of zopiclone and referred him to the mental health team. There is no indication that anyone from the mental health team assessed him, other than as part of a segregation review on 14 January 2013.

## **HMP Wayland**

30. On 16 January 2013, the man transferred to HMP Wayland. At the time he was prescribed diazepam (a sedative used to treat anxiety), gabapentin, methadone and tramadol.
31. On 27 March 2013, the man made a long cut of five to six inches on his left arm. As this had stopped bleeding when a nurse went to see him, she arranged for the wound to be sutured later. However, the man then barricaded himself in his cell and by the time he agreed to come out the wound was no longer suitable for suturing. The man said he was refusing treatment and told the nurses to leave the cell. He then began a dirty protest and was moved to the segregation unit where staff opened an ACCT.
32. The next day, the man spoke to a psychiatric nurse in the segregation unit and said that he wanted to go back to Liverpool to be near his family. He had complaints about his prison pay and food and said that these stresses had caused him to act destructively. He told the nurse that he had accidentally cut his arm while he had been smashing up his cell and had no thoughts of deliberate self-harm. He said he was not depressed and did not have any other concerns about his mental health. The GP turned down his request for zopiclone as the man had only recently finished detoxifying from diazepam and had declined alternative medication.

33. On 30 March, he asked for zopiclone again and said he needed it to prevent him getting angry from lack of sleep. The GP was reluctant to prescribe it, but she decided to compromise and gave the man a three day supply of zopiclone which he said would help restore his sleep pattern for months. The man did not get the zopiclone immediately because there was none in stock at the prison.
34. The man then refused to eat and started to smear his food on the cell walls. On 7 April, a nurse told him that he would not get any more medication until he started to eat again. The next day, the man made a deep two inch cut to his wrist. He was taken to the Norfolk & Norwich University Hospital because the cut was down to the tendons. On 9 April, he had a primary repair of his tendon. Wayland closed the ACCT that day.

### **HMP Norwich**

35. On 10 April, the man transferred to HMP Norwich. He told the nurse in reception that this had been the only time he had ever self-harmed. She noted that the man appeared subdued and depressed and that, despite receiving gabapentin and tramadol, he said he was still in pain. He told her he had taken 24mgs of illicit diazepam two days earlier. She referred the man to the mental health team.
36. A nurse saw the man later that day. He told her that he had self-harmed out of frustration at not getting zopiclone. She was concerned that the ACCT had been closed just before the man had transferred to Norwich without a proper assessment and re-opened the ACCT. A prison GP, prescribed zopiclone for seven nights.
37. A mental health nurse saw the man on 13 April. The man told her he had no history of mental health problems but that he had suffered from insomnia for many years. A sleep assessment was arranged. The man said that he wanted to be transferred to a category C prison.
38. On 24 April, the man cut his left arm. He said that no one cared and that although he used to take zopiclone long-term in the community, the GP at Norwich would not prescribe it for him. The mental health team planned to work with him to identify coping techniques to help him sleep and reduce his reliance on zopiclone. His sleep patterns continued to be assessed. Because the man was awake until 5.00am on 27 April, the GP agreed to prescribe three nights' zopiclone, but said that this would be the last such prescription.
39. On 29 April, the man self-harmed by making what were described as superficial scratches to his wrist and neck. He said he wanted zopiclone but was told he had already had one that day and the GP would not prescribe him anymore. The man would not let anyone assess the cuts. Later that night, the man made deeper cuts to his arm but continued to refuse to let nurses examine him. He demanded to be taken to hospital but the staff decided that this was not necessary. The next morning, 30 April, a doctor saw the man

and recorded that he had been using self-harm to try to manipulate the night nurse into giving him zopiclone. The GP said he had already been prescribed zopiclone in line with national guidelines and explained that, due to the risks of tolerance and physical dependence, zopiclone was only recommended for short-term relief of insomnia or infrequent use for longer terms. The man was unwilling to try any other medication.

40. The man made several cuts to his left wrist that afternoon. The cuts continued to bleed and the man started to drift in and out of consciousness. The man had to be persuaded to go to hospital. Eventually, he got into an ambulance, but then became aggressive and refused to go. He was taken to constant watch cell and told staff he 'wanted to bleed out'. The staff warned him about the risks of what he was doing, which included infection, sepsis, and possible death. Later that day, he told a mental health nurse that he did not know why he had behaved that way. He said that he was finding having his sleep monitored difficult and that he had only just started to self-harm.
41. Over the next few days, sleep monitoring established that the man had slept for only a few hours each night. On 3 May, he was prescribed zopiclone again to help him sleep. When this prescription finished, the man found he could not sleep again for more than a few hours a night. The GP prescribed a further five nights of zopiclone on 8 May. In mid-May, the GP agreed that the man would get five days of zopiclone every two weeks with a reducing amount every fortnight.
42. Towards the end of June, a move to Blundeston was agreed. On 2 July, the man threatened to self-harm because he was not getting enough sleep and felt unsupported. He said he would cut himself in order to get to hospital. The nurse explained to the man that they could only prescribe zopiclone in line with British National Formulary (BNF) rules.

### **HMP Blundeston**

43. On 12 July, the man transferred to Blundeston. At reception he said he had no current thoughts of self-harm. On 15 July, the prison GP referred him to the mental health in-reach team. The GP repeated his prescribed medications and also prescribed zopiclone – one to be taken every other night, for six nights.
44. A member of staff from the mental health in-reach team, considered the GP's referral. He noted that the GP had recorded that the man had violent outbursts and probably undiagnosed mental health issues. The member of staff from the mental health in-reach team reviewed the man's medical record and concluded that his behaviour was probably drug related rather than a mental illness or disorder. He decided not to see him.
45. On 1 August, the man told the GP that he had a poor sleep pattern and had been on zopiclone for a long time. He said he was anxious about having it reduced. At that time he was prescribed gabapentin, tramadol and

methadone. He also had a prescription for one or two zopiclone tablets at night.

46. On 8 August, wing staff referred the man to the mental health team but the member of staff from the in reach team noted that the man's issues appeared to be related to sleep and drug-seeking. He did not think that the man appeared to have a severe or enduring mental health issue and therefore did not go to see him. He believed it was he felt the responsibility of the GP and the substance misuse team to manage the man's sleep problems. A mental health nurse, noted that they had received a letter from the man's solicitor on 16 August, asking for his medications to be reviewed and for him to be seen by the mental health team. She recorded that the man did not have secondary mental health care needs.
47. Towards the end of August, the man began a dirty protest and was moved to the segregation unit. His behaviour was difficult to manage and he smashed up cells and flooded them. He kept asking for sleeping tablets and calmed down when he was given zopiclone. His behaviour improved substantially for the few days and another prison GP, continued the zopiclone prescription on 28 August. The next day, the GP decided that it was in the man's best interests to stop the zopiclone. Instead, she prescribed an alternative, promethazine, which the man refused to take.
48. The GP thought that the man might have mental health problems secondary to his drug misuse and referred him to the mental health team again on 2 September. She saw the man on 6 September when he was still in the segregation unit and he told her that other medication did not help him sleep. He said that he had disturbed sleep every night and that he had taken zopiclone on a long-term basis in other prisons. He acknowledged that he was dependent on zopiclone, but said doctors had always prescribed it for him in the past. The GP told him that zopiclone should not be taken long-term and that he was already on several other medications. She decided to prescribe zopiclone on a reducing basis – one tablet every day for 14 days and then one tablet every other day for 14 days (ending on 3 October). The man was also unhappy about having to take his medications in front of healthcare staff.

### **2-3 October 2013**

49. Around 3.00pm on 2 October, the man cut his left arm and an ACCT was opened. A nurse attended and thought that some of the blood was spurting from an artery and called an ambulance at 3.08pm. Initially, the man refused help, but then allowed the nurse to use a tourniquet to help stop the bleeding. When paramedics arrived at 3.19pm, the man said he would not go to hospital unless he was given medication as he was very anxious. The GP gave permission by telephone for him to be given 5mgs of diazepam. He then agreed to go to hospital and the ambulance left Blundeston at 4.39pm. The ambulance crew estimated that he had lost just under 200mls of blood.

50. A doctor at the James Paget Hospital saw the man at 5.10pm. The man told her that he was frustrated about the management of his chronic back pain for which he was prescribed gabapentin and tramadol. He said that the pain had become very bad that day and he had cut himself because he felt the prison doctor was not listening to him. The man had not damaged the tendons or muscles in his arm and the doctor offered to stitch the cut, but he refused. Steri-strips and glue were used to close the wound instead.
51. The doctor suggested that he needed to be referred to the hospital's pain clinic, but the man told her that he doubted that this would happen and asked for some diazepam. The doctor told him diazepam was not good for the long-term management of back pain, but after discussing this with her consultant she gave the man a small amount of diazepam (14 tablets of 2mg each). She was not aware that the man was not allowed to keep his own medication at the prison and the escorting officers did not question him being given medication. The doctor wrote in the discharge summary for the prison that the man should be referred to the pain clinic and have physiotherapy. The man returned to his cell on D wing at 6.20pm and the box of diazepam was found to be empty the next day.
52. An officer carried out an ACCT interview on the morning of 3 October. He noted that the man said he was having a lot of back pain and felt unsupported by healthcare staff. The man told him that he had self-harmed the day before because he had felt isolated and frustrated at not having a prison job which meant that he did not have enough money to buy tobacco. The officer noted that getting a job would help the man's situation. He did not think the man was suicidal and thought he had cut himself as a coping mechanism and as a way of getting the medication he wanted.
53. At 2.55pm on 3 October, a custodial manager held an ACCT first case review which another officer attended. The officer who carried out the ACCT interview that morning was not there, although the written summary of the meeting suggests that he was. (The custodial manager said that the officer had briefed him before the review.) The custodial manager noted that the man was in a fairly positive mood and had just had his dressings changed. The man said that his issues stemmed from not having a job and therefore not having any money to buy tobacco. This meant that he had to do things for other prisoners or beg tobacco from them. At the review, the custodial manager arranged for the man to begin a job in the prison laundry the next Monday. The custodial manager said he thought that the man was quite motivated to get a job, earn money and be able to buy tobacco and other items from the prison shop. As he thought the reason behind the man's self-harm had been resolved, he closed the ACCT.

#### **4 October 2013**

54. On Friday 4 October at about 4.00pm, the man collected his evening medication (gabapentin). He asked the pharmacist, who was issuing medication, for zopiclone but his prescription had ended the day before. The

man said he was going to “chop up” so that he could go to hospital. An officer re-opened the man’s ACCT at 4.30pm.

55. In case the man should need to be taken to hospital again, the healthcare manager, wrote a letter for the Accident & Emergency Department at the James Paget Hospital explaining that the man was on a methadone programme and his medication was managed by the prison. He asked that the man should not be given medication to bring back to the prison.
56. The duty manager that evening, spoke to the man to try to persuade him not to self-harm, but he would not agree. The duty manager held an ACCT review at 4.45pm which an officer also attended. The duty manager assessed the man’s risk of further self-harm as high and that he intended to manipulate the situation to get more medication. He decided that the man should be observed every two hours through the night. The duty manager and officer did not consider whether any items with which the man might be able to harm himself should be removed from his cell.
57. The man went back to his cell at lock up time (5.10pm). A prisoner told us that another prisoner had given the man some zopiclone tablets and that he was therefore not too unhappy at that time. The duty manager had asked another officer to base himself on D wing in case the man carried out his threat to self-harm and at 5.30pm, when all the prisoners were locked up, the officer joined another officer on the wing.
58. The control room rang D wing office at 6.20pm and told the officer that the man had pressed his cell bell. The officers went upstairs and saw through the observation panel in the door that there was a lot of blood on the floor of the cell. The man said that he had a blade and would attack anyone who came in. The officers asked the duty manager to attend, but neither officer called an emergency code (which indicates a loss of blood and should result in an ambulance being called).
59. The duty manager got to the cell a few minutes later and the man continued to threaten to attack anyone who went into his cell. The duty manager did not consider that the man was in any immediate danger and decided to leave the wing to ring 111 for advice. (111 is an NHS service for non-emergency help or advice.)
60. An officer noted in the ACCT document that the man had made an unknown number of cuts on his left arm and that there was a massive amount of blood on his arm and the floor. The two officers said that they could hear blood dripping from the man’s arm, but he still would not let them go into the cell to help him.
61. The duty manager telephoned 111 at 6.33pm and the call lasted for 13 minutes. He said the call was difficult because he was not with the man so could not give the call handlers up to date information. They advised him to take the man to hospital. The duty manager said the operator had not told

him to ring 999, so he spent the next few minutes planning how to get the man to hospital.

62. While the duty manager was away making the call, and the two officers said that they did not observe the man constantly, but at least one of them remained on the landing no more than four metres from his cell. Some prisoners alleged that the officers had told the man to apologise after he had threatened to “throw shit” on them and had left the man alone. The officers denied that they had told the man to apologise or that they had left the landing unattended. It does not appear that either of the officers were directly outside the man’s cell at 6.35 pm, because at that time he pressed his cell bell and said he was struggling to breathe. The officer said he asked the man if he would let staff and paramedics treat him, but the man kept saying he needed his medication and that he was angry. The officer said he could tell the man was losing a lot of blood because he seemed to be swaying and was not able to stand properly.
63. The duty manager did not come back to the wing until just before 7.00pm. He said he was concerned about how much the man had deteriorated so radioed the communications room and asked them to call an ambulance. An ambulance was called at 7.02pm. The communications room officer told the call handler that a prisoner had cut himself badly. When the call handler asked if there was a nurse or doctor with him the officer said that there were two staff with him and he did not think that the man was violent or still had a weapon. None of these answers were correct and he was unable to tell the call handler whether there was any serious bleeding. The East of England Ambulance Service gives top priority calls a target response time of eight minutes and a target of 30 minutes for less urgent incidents. On the basis of the information, the call was not given top priority. Two ambulances were despatched to Blundeston, one immediately and one at 7.13pm but both were re-routed because of higher priority calls. A third ambulance arrived at Blundeston at 7.41pm.
64. At some time after 7.00pm, the man’s cell door was opened and he was given a pot and a toilet roll as he said that he needed to use the toilet. The officer said that the man had stopped making threats to staff at this stage and was quite calm. The officer said there was a very significant amount of blood. He thought the cell door was left unlocked and ajar from this time, but the staff did not go in. The officer described the level of blood as “pretty horrific”, but the man refused a bandage for his arm. The officer thought the man seemed weak, but did not think that he lost consciousness at any time.
65. Paramedics got to the man’s cell at 7.50pm and began to treat him. At 8.10pm, they noted that he had a normal heart rate, slightly elevated respiratory rate, low blood pressure (93/50), slightly reduced level of consciousness and a reduced amount of oxygen in his blood. They gave him oxygen, dressed the wound and took him to the ambulance accompanied by the other officer.

66. The supervising officer on duty overnight on 4 October, arrived at the gate for duty at around 8.10pm when the duty manager told him he needed some staff to go to the hospital with the man. The ambulance was then delayed in the gate area while this was arranged. One of the night staff was asked to accompany the man to hospital and an officer who was about to finish her shift, agreed to be the other escort officer until she could be relieved. The man was restrained using an escort chain.
67. The lead paramedic said it took about 18 minutes to leave the prison. Some of the delay was caused getting the ambulance through the internal gates, but most was caused by arranging officers to go to hospital. An operational support grade (OSG) said he thought the ambulance waited at the gate for ten minutes.
68. The ambulance left at 8.26pm and arrived at the James Paget Hospital at 8.35pm. The ambulance crew had warned the A&E department of their arrival because they were concerned at the potential for hypovolaemic shock (which occurs when there is not enough blood for the heart to pump around the body). The man was conscious, but one of the paramedics had to rouse him with painful stimuli during the journey. His legs were elevated to increase blood flow to his vital organs. (The paramedics suggested this might explain an improved blood pressure reading shortly after he arrived at hospital.)
69. The man was booked into the A&E department at 8.43pm. A nursing sister recorded a pulse of 100, blood pressure of 117/43 and a respiratory rate of 16. The nurse said the man had a lot of blood on him so she brought him a bowl of water so he could wash himself. She put up a saline drip but very little went through before the man ripped out the line and refused to have another one put in. No further observations were recorded while the man was at the hospital that evening, although an A&E doctor said that medical observations are taken routinely for all A&E patients every 30 minutes.
70. The doctor first saw the man at 8.46pm. The man requested 'something for stress' and the escort officers gave the healthcare manager's letter about his medication to the doctor. The officer said the man was frustrated with waiting and said it was clear he wanted medication. The officer was relieved by the custodial manager soon after 9.00pm and went off duty. The custodial manager said that the man asked continually for medication for an anxiety condition.
71. The doctor spoke to the man at 9.55pm. He was quite calm but still bleeding from his arm. His haemoglobin (a protein in the blood which carries oxygen) concentration was 9.8 g/dL (the normal range for men is 13 – 18). His white blood count was 19.5 (the normal range is 4 – 10). At interview, the doctor said that he thought the man was on the verge of going into hypovolaemic shock and that he would not have needed much more blood loss to put him in danger. He told the man that he needed a blood transfusion and planned to give him two units of blood and keep him in hospital overnight. The man asked for medication for anxiety.

72. Another officer said the man threatened to discharge himself from hospital if he did not get medication for his anxiety. He said the man's arm was not bleeding the entire time they were in A&E, but that it kept re-bleeding as the man picked the clots off.
73. The custodial manager wrote in the escort record that the man was trying to dictate his treatment, demanding medication (zopiclone and gabapentin) and becoming more aggressive and argumentative. The doctor told the man that because he was already on medication it was not advisable to give him further drugs that he did not need. The man began to shout and swear and said he was legally entitled to medication for his anxiety. He refused to have a blood transfusion and the doctor was satisfied that the man was mentally competent to refuse treatment. The hospital staff tried to persuade him to have the blood transfusion and said that if he refused there was no point him staying in hospital. Each time a nurse dressed the man's arm he took the dressing off, picked at the wound and made it bleed again.
74. The doctor wrote in the hospital record at 10.49pm that the man had refused any further treatment and wanted his cannula removed. The doctor noted that he had explained the risks and that the man could go back to prison. He did not arrange for a mental health assessment. The doctor said at interview that he did not think the man was suicidal and he felt that by not giving the man the medication he wanted, it might stop further episodes of self-harm as he would realise that self-harming was not productive.
75. The man told the staff that if he did not get any medication they would have to bring him back when he started bleeding again at the prison. The custodial manager said at one point the man told him to take him back to the prison and got off the bed and tried to walk out of the cubicle. He was persuaded to get back on the bed as his legs were weak from low blood pressure.
76. The custodial manager said that he wanted to clarify with the doctor that he was content for the man to leave hospital and asked the doctor if he agreed to them arranging transport back to the prison. The doctor said he could not do the transfusion without the man's consent and that he could go back to Blundeston. At interview, the doctor said that he had told the man that he would be in trouble if he kept bleeding, but did not specifically warn him that he risked dying. The doctor believed that the man's observations had improved, and would continue to improve, as long as he did not bleed any more. The doctor did not see the man again before he went off shift and left shortly after 11.00pm.
77. At 11.15pm, the custodial manager wrote in the escort record that the man had reopened his wounds and caused them to bleed profusely. He had been given pads to absorb the bleeding. The custodial manager telephoned the prison at 11.23pm and asked for a change of clothing for the man and for the prison van to come and collect them.
78. The nursing sister said she asked the officers to keep a close eye on the man. She was concerned about the significant amount of blood he had lost and that

he might harm himself. She said she emphasised to the officers that they could bring him back if they had any further concerns or if the man changed his mind and decided to accept treatment.

79. The custodial manager said he did not remember getting any specific advice from the doctor or Sister about the circumstances in which they should bring the man back to hospital and they do not appear to have been given any specific information about what should trigger a need for urgent intervention and a return to hospital such as if he started bleeding. The doctor told us that he was aware there were no healthcare staff on duty at Blundeston at night, but he thought it was common sense that if someone reopened a cut or cut themselves again and began bleeding that they should be taken back to hospital. Both the doctor and Sister said that they expected the man to be back in hospital within a few hours.

### **5 October 2013**

80. The duty manager, who had stayed on duty, drove the prison van to the hospital and arrived just before midnight. He did not discuss with the escort staff whether they considered the man was fit to leave hospital. They assumed that the hospital staff would not allow the man to leave if it was not all right to do so. The duty manager said in his police statement that the man had reopened his wound and said that he needed to see the doctor. However the duty manager knew that the doctor who had seen the man had now gone off duty. At 12.25am, they arrived back at the prison.
81. The duty manager decided, after discussion with the supervising officer (SO) that the man should stay in the segregation unit for the night where he could be observed frequently and more easily than on D wing. It would also make it easier to take him to hospital again if necessary. The man was able to walk to the segregation unit with staff supporting him. The custodial manager said he was not uncooperative. The duty manager did not hold a formal ACCT case review, but decided that the man should be observed five times an hour at irregular intervals. This was not recorded on the ACCT document, but he informed the segregation unit staff who recorded this level of observation. The CCTV cameras in the segregation unit had been out of operation for some time so there is no other record of checks or events in the segregation unit that night.
82. The custodial manager and the duty manager left the prison shortly afterwards. Neither the manager nor the SO had spoken to the duty governor about the events that night or to discuss locating the man in the segregation unit.
83. At night, Blundeston operated with one supervising officer, three officers and seven or eight support staff. There were about 330 prisoners in Blundeston that night. The SO was in charge of the prison and said the officer had told him that the hospital had not given any advice about the man's care. He said he was not unduly concerned about the man returning to the prison because he thought the hospital would have insisted he stayed if that was necessary

and would have warned him of the serious consequences of refusing treatment.

84. The man was very unhappy about being put in the segregation unit because he was not allowed to smoke there. (The segregation unit was a no smoking area and neither staff nor prisoners had access to tobacco.) When he learnt this, he threatened to smash up the cell and assault staff. He shouted for several minutes and the SO thought he had smashed his toilet seat. The SO said the man demanded medication and said he wanted to go back to the hospital.
85. Soon after, the man opened up the wound on his arm and made it bleed again. He pressed the cell bell and told the officer that he needed to go back to hospital. The officer said in his police statement that the SO decided that the man was not going back to hospital, because he believed that this would “be the story for the rest of the night” if they did. The SO said he did not go back to the segregation unit to assess the man, but had been told that blood was not gushing out and that there had been just a couple of little drips which then stopped. He did not consider taking the man back to hospital, even though he had asked to go back. The SO was unsure what time this was but it appears to have been around 12.30am. At 12.41am, the officer recorded that the man was asleep.
86. At about 1.00am, the SO arranged for an operational support grade to help the officer carry out the required checks on the man. At that time, the OSG said the man was asleep. The OSG said he and the officer agreed between them that he would then have a break until about 3.00am and then the officer would have a break until 5.00am. The OSG went to the Listeners’ room where he had a drink and read a newspaper. He was not in the segregation unit as the SO had intended.
87. The officer made the same entry in the ACCT document (“Asleep on bed, breathing seen”) for the observations until 3.15am. Soon after 3.00am, there was a radio test call which seems to have woken the man. The OSG returned to the segregation unit and said he more or less constantly observed the man from this point onwards. The man asked for a cigarette but was told he could not have one. He told the man to lie down and not to stand up.
88. The officer called the SO around 3.30am. He told him the man was asking for an extra blanket because he was cold. The SO went to the segregation unit and staff unlocked the man’s cell and gave him a blanket and a drink of water. The SO remained in the segregation unit for five or ten minutes after this and he did not consider that the man’s condition had deteriorated – he was unsteady on his feet when he stood up but all right when he was sitting down. The SO said there was some blood smeared on the cell floor which the officer told him came from when the man had picked at his wound and made it bleed a little. None of these events, including the additional blood loss, were recorded in the ACCT ongoing record. The entries in the ACCT around this period were as follows:

3.29am "still trying to get a smoke"  
3.39am "is awake talking nonsense"  
3.50am "rolling around on bed, awake"

89. Between 4.00am and 4.40am, the ACCT entries state that the man was on his bed but awake. The next entry ten minutes later records him asking for tramadol.
90. The OSG said he remembered the man shouting that he wanted a jug of water. He also kept asking for a cigarette and to see the person in charge. He said his leg was swollen. The OSG told the man to lie down because he was unsteady on his feet whenever he stood up. He said the man asked to go back to hospital. The OSG said the man also complained about his head but said he could not remember why he said it hurt. He said he did not see the man ever hit his head on anything. In his police statement, the OSG said, "We got the impression he wanted to go back to hospital as he hadn't been given any medication".
91. The officer said in his police statement that between 3.00am and 6.00am he and the OSG were at the man's cell most of the time. The man had urinated and defecated in the cell and there were smears of blood on the walls and floor. The officer said the man demanded to be taken back to hospital. There is no record of this in his ACCT document and there is no evidence that this led to any consideration as to whether the man needed to be taken back to hospital. The officer believed that the man just wanted to disrupt the regime as much as possible by going to and from hospital. At 4.40am, the officer turned the cell light off to try to encourage the man to go to sleep again, but this did not help so he switched it on again as it was easier to observe him.
92. At 5.00am, the officer wrote in the ACCT that the man was becoming very frustrated because he was unsteady on his feet. The officer told him it was probably due to low blood pressure and that he should stay on his bed. He said the man was screaming and shouting in anger. Over the next hour, the officer recorded in the ACCT documents entries such as – The man started "shouting for meds", "becoming very demanding, saying he can't cope", "asking for oxygen", "still shouting and screaming" and "rolling around on floor. Trying to talk some sense to [the man] but not getting through". This last entry was recorded at 6.00am. In his police statement, the man said that he had last spoken to the man at 5.40am when he was asking for oxygen.
93. The SO said he had looked in on the man at about 5.30am. At the time he was lying on the floor demanding tobacco and medication. Ten minutes later, the SO was on D wing and said he could hear the man shouting.
94. At around 6.00am, the OSG went to the gate to let in day staff. The officer went to the segregation unit office to fill in the ACCT and other handover books. He said that as he was writing, the man went quiet. In his police statement, the officer said he went to check on him immediately, but when we interviewed him he said he was writing up his papers and checked the man about five or ten minutes later. He looked through the observation panel and

saw the man lying on the floor. His chest and stomach area were not moving. He could not see his face as the man was lying with his face near the cell door. The man realised that something was wrong and kicked at the cell door and called the man's name, but he did not respond.

95. The officer radioed to ask the SO to come as soon as possible. He did not call a code blue as he should have done in a medical emergency. The clock on the radio computer timed this call at 6.09am. (The hand-written communication room log recorded the radio message as being at 6.20am but other information indicates this was erroneous.) The officer said he believed he might have been at risk of attack if he went into the cell on his own. The SO was in the gate when he heard the radio message and immediately ran to the segregation unit via A wing. He thought it took him less than five minutes to get there.
96. An officer was the assistant night orderly officer and said he was on A wing when the SO came running to get him. The assistant night orderly officer said the SO told him the man was not in a good way and had been banging his head on the ground. They ran to the segregation unit. The CCTV recording of the area outside the segregation unit showed the officer looking down the corridor at 6.13am to see if any members of staff were coming. Another operational support grade (OSG) was on C wing when he heard the radio message. He said he was not sure what had happened, but thought that additional staff might be needed so decided to go to see if he could help. At 6.15am, the SO, assistant night orderly officer and the OSG arrived at the segregation unit.
97. The SO looked through the cell observation panel and saw the man lying naked on his back with his head towards the door. He opened the cell door and the staff went in. The assistant night orderly officer said the man was lying on the floor with his head near the door and there were "patches" of blood in the cell. The man was unresponsive and they started to attempt resuscitation by giving chest compressions. The SO asked for an ambulance to be called.
98. The SO brought a defibrillator (a life-saving device that gives the heart an electric shock in some cases of cardiac arrest) from the centre office. The SO said that the OSG switched the machine on. The machine instructed them to attach the chest pads but the assistant night orderly officer said that the defibrillator did not work when the OSG tried to use it. The OSG said he attached the pads to the man's chest and that the machine said it was checking rhythm but then instructed to continue with resuscitation. The SO said afterwards he learnt that the pads only attach properly if there is no hair on the chest. He said he remembered hearing the automatic voice on the machine.
99. Another OSG had been carrying out a cell check on D wing. He heard the radio message but did not think it was an emergency and went to the segregation unit after he had finished his roll count. He said there was blood in the cell, but nothing like the amount of blood that had been in the man's cell

on D wing the night before. The OSG said the other staff had already tried to use the defibrillator. He said the battery was flat and had totally discharged itself. He did not know if it had been working when the staff tried to use it earlier but by the time he got there the machine was outside the cell.

100. The East of England Ambulance Service logged the 999 call at 6.19am. The ambulance and rapid response vehicle both arrived at the gate at 6.30am. It took a further five minutes for the emergency team to get to the segregation unit cell.
101. The prison staff continued chest compressions until the paramedics got to the cell at 6.35am. The paramedics were unable to get a cannula into the man's arm. They attached their own defibrillator but no shock was administered. At 6.44am one of the paramedics, pronounced the man's death.
102. In his police statement, the paramedic said there was "a substantial amount of blood on the floor and walls..." He said that he could see the prison defibrillator on the floor, still zipped in its bag and that there were no used pads in the cell. The paramedic commented:

"I know that he had been into hospital the previous day, having lost a substantial amount of blood and had refused a transfusion. With the amount of blood that was in the cell I would say that he had probably lost around half of his body's blood. That alone would have been enough to kill someone".
103. The paramedic clarified to the clinical reviewer that he had meant that the man would have lost around half of his total blood volume collectively over the period from 2 to 5 October.
104. The duty governor arrived at the prison and held a debrief for the staff who had been involved in trying to resuscitate the man. Most staff said they had felt supported by the prison in coming to terms with what had happened.

### **Family liaison**

105. The prison appointed a family liaison officer. Because of the distance to the man's family's home, the family liaison officer contacted one of the family liaison officers at HMP Liverpool at 10:00am and asked him to break the news to the man's family. Liverpool's family liaison officer and a prison chaplain went to the man's family's home, arriving at 12.15pm and informed them that the man had died. The family liaison officer gave them the contact details for the family liaison officer at Blundeston.
106. Blundeston offered a financial contribution towards the funeral in line with national policy. The family visited the prison and met some of the staff and prisoners who had known the man.

## **Post-mortem report**

107. The toxicology report showed the man had levels of diazepam, mirtazapine (an anti-depressant), zopiclone and methadone in his blood. The amounts detected were unlikely to have contributed to his death.
108. There were several cuts to the man's left forearm. One of these cut the radial vein and the pathologist thought that the man would have continued to bleed for some time from this wound. As a result of the cumulative blood loss, the man collapsed (a condition known as hypovolaemic shock).
109. The post-mortem found that the cause of death was:
  - 1a Hypovolaemic shock
  - 1b Incised wounds to the left forearm.

## ISSUES

110. The actions of staff at the James Paget Hospital are not within the remit of the Prisons and Probation Ombudsman and thus are outside the scope of this investigation. However, we have sent this report and the clinical review to the hospital management for their information. Several clinical issues are covered in depth in the clinical review.

### **The man's mental health and self-harm**

111. Blundeston had a small number of mental health staff in the healthcare team. There was no primary mental health team or primary therapeutic services such as counselling or behavioural therapies. We were told that the man was offered places on one-to-one and group sessions for relapse prevention and reduction support through substance misuse services but declined to participate. The man received primary mental health care from the GP who referred him to the mental health in-reach team on 15 July and 2 September 2013. At the beginning of August, wing staff referred the man to the in-reach team and his solicitor wrote on 16 August asking for him to be seen. Despite these various referrals the in-reach team did not assess the man.
112. A member of staff from the in-reach team said that when he reviewed the man's medical notes there was little evidence to suggest he had major mental health problems. Even at a primary level, he was not on medication for any mental health problems. The member of staff from the in-reach team felt that, if anything, the man had sleep and drug-related issues. He said that the man was discussed at some of the in-reach team meetings because of the repeated referrals, but the team decided not to see the man for assessment because they did not think he had severe and enduring mental health problems.
113. The in-reach team was aware of the man's self-harm on 2 October. The member of staff from the in-reach team said he thought that the man self-harmed to go to hospital in order to get medication. He considered that the man had harmed himself on 4 October because he had got the medication he wanted the previous time.
114. Some of the man's self-harm was very severe. His stated reasons behind the self-harm ranged from him feeling very aggrieved that his requests and demands (usually for zopiclone) were not being met or in response to complaints of pain and insomnia. A doctor who contributed to the clinical review, said that people who self-harm repeatedly often have a disordered personality and their acts are often designed to elicit a response from others. The man's behaviour suggested a considerable degree of impulsivity, excitability and quick-temperedness.
115. The doctor concluded that on the face of it, the man did have mental health issues. His behaviour could have been a manifestation of disordered personality exacerbated by insomnia and substance misuse but this does not appear to have been comprehensively assessed by suitably qualified mental

health professionals, such as a consultant forensic psychiatrist or, in view of his demands for medication, an experienced clinician with knowledge of substance misuse.

116. In the light of the clinical review, we conclude that the man's drug-seeking behaviour should not have prevented a mental health assessment being undertaken and that an assessment would have been appropriate. We therefore do not consider that the man's mental health needs were effectively met.

### **ACCT procedures**

117. An ACCT was appropriately opened on 2 October in response to the man's self-harm. An officer carried out a comprehensive assessment interview the next morning. We are concerned that the ACCT was closed so quickly after this act of self-harm, at the first case review later that day.
118. The record of that review suggests that the officer who carried out the interview was present, but this was not the case. The officer said that had he been present he would not have agreed to the ACCT being closed. The custodial manager said that he had been briefed by the officer, yet the officer says that the custodial manager did not contact him so he was unable to present his views from his assessment that morning.
119. The ACCT caremap indicated that lack of employment was the only underlying issue that arose at the first case review. The man's frequent issues about medication should also have been recorded as an issue on the caremap, as this seemed to be of more concern to him. A member of the healthcare team should have been present at the ACCT review to help address this issue.
120. The custodial manager felt he had resolved the employment issue by arranging for the man to have a job in the laundry. The job would have started the following Monday (the review was on the Thursday). However, four more days had to pass before the laundry job would start and it is difficult to understand the decision to close the ACCT at that time. He had cut himself badly enough to need hospital treatment just the day before and not for the first time. He had threatened to self-harm again just 35 minutes before the case review meeting started. While the employment issue was on its way to being resolved, it was premature to close the ACCT at that stage. At the very least, it would have been prudent to have kept the ACCT open until the job started on the Monday and to arrange a review after that.
121. In the event, the ACCT was reopened on 4 October after the man threatened to self-harm again. This underlines why it should not have been closed on 3 October when there was little evidence that the man's risk had reduced. During interview the custodial manager agreed that in hindsight, he was too quick to close the ACCT. The ACCT review on 4 October again did not have any healthcare representation so did not address the man's underlying issues about his medication.

122. Prison Service Instruction 64/2011 'Management of Prisoners at risk of harm to self, to others and from others' states that the first case review should "Consider and agree whether any items which the prisoner might use to self-harm should be removed from them...". Although it was recognised that the man was now at high risk of self-harm there was no consideration of whether the man needed to have any items removed which he might use to self-harm. Less than two hours later the man used a razor to cut himself.
123. There were also deficiencies in recording events in the ACCT ongoing record during the man's time in the segregation unit. Some time shortly after 12.30am, staff interviews indicate that the man opened up the wound on his arm, made it bleed some more and asked to go back to hospital. A decision was made not to take the man back to the hospital yet none of these important matters affecting the man's safety were recorded in the ACCT. Around 3.30am, his cell was unlocked to give him a blanket and drink of water and this was not recorded. The officer made all the entries in the ACCT document even though the OSG had completed many of the checks. The OSG told us that he did not know what the officer had written.
124. We are not satisfied that the ACCT procedures at Blundeston operated effectively to identify and help reduce the man's risk. Neither of the reviews were multidisciplinary and the careplans did not adequately reflect his needs, level of risk and the triggers of his distress. The ongoing record did not capture all the key events and relevant information about his risk and mood.

### **Integrated care for prisoners with complex needs**

125. The man's health problems and drug dependency needs and behaviours posed particular and complex challenges to providing him with safe and appropriate medication. Decisions about his medication had a direct impact on his behaviour and level of risk to himself, healthcare and prison staff.
126. We believe that Blundeston should have taken a more integrated approach to managing the man. While there were informal discussions between clinicians from services such as primary care, integrated drug treatment services and substance use workers, there was no formal documented evidence of an integrated approach to planning and managing his care, especially in relation to prescribing decisions. There were no multidisciplinary meetings involving a mix of healthcare and prison staff.
127. Prison staff were often unaware about decisions affecting the man's medication, which made it difficult for them to manage the impact the changes had on the man's behaviour and demeanour. Prison Service Instruction 'Management of prisoners at risk of harm to self, to others and from others' (PSI 64/2011) sets out the need for healthcare and prison staff to meet together to discuss issues related to the safety of prisoners and the management of prisoners with complex needs.

128. The clinical reviewer commented that prisoners like the man with complex substance misuse and possible dual diagnosis issues (where individuals have both severe mental health problems as well as problematic drug or alcohol use) whose behaviour is sometimes hostile and challenging, are often held in prisons which do not have appropriate infrastructure, regime, security and healthcare funding to address their needs. Good quality healthcare for this group of prisoners and an integrated, whole prison approach to their management is crucial in enabling their rehabilitation yet this did not appear to be available for the man at Blundeston.

### **Communication between HMP Blundeston and the James Paget Hospital**

129. It is evident that there were some liaison and communication problems between the prison and the hospital which had the potential to compromise the man's care. Had the prison still been open this would have indicated a need for the prison to develop a protocol with the hospital to improve communication.
130. No discharge information was sent when the man returned from the hospital on 2 October after treatment for cutting his arm. The man had been given some diazepam at the hospital, but the escorting officers did not report this when they returned. A member of the healthcare team telephoned the hospital the next day to obtain a copy of the discharge letter to identify exactly what medication he had been given. This was indicative of poor communication between both the hospital and healthcare staff at Blundeston and also between officers and nursing staff in the prison.
131. The hospital's decision to give the man some diazepam on 2 October was not an inappropriate clinical decision but seems to have been made without an awareness of the circumstances and risks for medicines management in the prison context. Appropriate briefing by the prison would have helped avoid this. Instead the decision led to a letter from the healthcare manager at the prison requesting that the man should not be sent back to the prison with medication. The doctor interpreted this as meaning he should in future deal only with the man's self-harm and not give him medication for other problems. The clinical reviewer said it was not clear whether the letter was meant to be instructional or advisory. The healthcare manager said it was his intention to give background information. The doctor said the letter could have affected his judgement about whether to prescribe diazepam to treat the man's anxiety when he refused treatment, on 4 October. In the event, he decided it was not clinically safe to give him a sedating drug when he had lost so much blood.
132. The clinical reviewer said it is good practice to provide clinical information to healthcare colleagues when patients are transferring between settings. However, the health care manager's letter did not include a summary of past medical history, current medications prescribed, mental health status or specialist information, such as whether medication is not held by the patient.
133. Apart from the doctor the hospital staff we spoke to said that they were unsure about the healthcare arrangements at Blundeston and in particular what the

arrangements were for out of hours cover. Although the man effectively discharged himself from the hospital when he refused treatment on 4 October, there were again communication difficulties. This meant that the escorting officers did not return to the prison with any clear information about the man's ongoing care and in what circumstances he should be brought back to hospital.

134. We consider it is important for the care of prisoners that prisons develop effective liaison with local hospitals, in particular to ensure that hospital staff have no misunderstanding of the level of healthcare available in the prison. It does not appear that Blundeston had such a relationship with the hospital.

### **Emergency response**

135. The man lost a significant amount of blood before he was taken to the hospital on 4 October. This was a key factor in his death from hypovolaemic shock. In her specialist report about the emergency care given to the man on 4 October, a consultant in emergency medicine, said that it was highly likely the delay in receiving appropriate treatment contributed to the man's death.
136. There were several reasons why the man lost so much blood and did not arrive at hospital until 8.35pm, despite his initial cuts being discovered at 6.20pm, some two hours 15 minutes earlier. As noted earlier, there was no discussion at the ACCT case review on 4 October about whether to remove items from the man's cell that he might use to cut himself. Had his razors been removed it would have been more difficult for him to have made such a deep and serious cut to his arm.

### *Calling an ambulance*

137. The man first alerted prison staff at 6.20pm on 4 October that he had cut his arm. It was evident that he had lost a lot of blood. The national instruction to staff on Medical Emergency Response Codes is PSI 03/2013. The local policy published in response to this (February 2013) states that staff who discover a prisoner who has had a "severe blood loss" should radio a code red which should automatically trigger the control room to call an ambulance. There is no doubt that the man had severe blood loss and we consider that the officers who responded should have called a code red immediately which would have resulted in an emergency ambulance being called.
138. When the duty manager arrived he did not consider that the man was in immediate danger so called 111 for advice rather than an emergency ambulance. He did not do that with any haste and, as he was not with the man at the time, was not able to give accurate up to date information. Despite the evident blood loss, the duty manager noted that the man was still coherent, still fully aware of the situation and answering questions. This was contrary to the local instruction about severe blood loss and a particular concern as there were no healthcare staff in the prison at that time. In the circumstances, it should have been apparent that the man needed to go to

hospital urgently. The man continued to bleed for a further 40 minutes before an ambulance was called.

139. Once the ambulance was called there was miscommunication with the ambulance service and the urgency of the situation was not conveyed to them. The communications officer did not have sufficient information and gave the impression that the staff were actually with the man when he was locked in a cell on his own. (It is possible the ambulance staff got the impression it was healthcare staff who were with him.) This resulted in the downgrading of the priority of the ambulance response. No one contacted the ambulance service again to say that the situation was urgent.

#### *The delay in the ambulance leaving the prison*

140. The paramedics reported that it took 18 minutes for the ambulance to get out of the prison once they were ready to leave. Some of this time was while the ambulance was moving through the prison, but most of the hold up was at the prison gate waiting for escort staff. We consider it is unacceptable that an emergency ambulance should be held up for these reasons, particularly as it had already been anticipated that the man might go to hospital that evening. The man was not regarded as a security risk and if necessary the ambulance should have been allowed to leave the prison to be joined by the escort team at the hospital later. In such circumstances the lives of prisoners should take priority.

#### *Emergency response on 5 October*

141. When the man found the man collapsed and unresponsive at 6.09am, he did not radio a code blue emergency as he should have done. As with code red emergencies this would have automatically triggered the control room to dial 999 and ask for an ambulance. An ambulance was not called until 6.19am, some ten minutes later – an avoidable and unnecessary delay. It is not possible to know whether this would have affected the outcome for the man.

#### **Communication with the duty governor**

142. At night, when senior managers are not in the prison, the routine operation and security of the prison is the responsibility of a uniformed member of staff, known as the night orderly officer. A senior manager is also responsible for the prison 24 hours a day, known as the duty governor. The duty governor is on call throughout the night and should be available for advice if necessary. PSI 24/2011, which covers night procedures, requires the duty governor to be informed of any serious event during the night such as a death or emergency discharge to hospital. The instructions also require the duty governor to be informed if a prisoner is relocated to the segregation unit during the night state.
143. On the evening of 4 October, the duty manager, a custodial manager, was responsible for the operation of the prison until 9.00pm (although he stayed on duty for some hours after that) and from 9.00pm the SO assumed

responsibility, as the night orderly officer. Neither the duty manager nor the SO telephoned the duty governor to alert her to the serious situation of the man being taken to hospital and then returning without being treated and they did not seek approval for locating the man in the segregation unit as they should have done. The duty manager wrote an email for the duty governor when the man was taken to hospital on the evening of 4 October, which he expected would be read the next morning.

144. We consider that either the duty manager or the SO should have contacted the duty governor to inform her of significant events that were happening in the prison. We would have expected her to have been informed of the man's transfer to hospital and when he returned after refusing to accept treatment. Her approval should have been sought to locating him in the segregation unit, particularly as this should only be done in exceptional circumstances for a prisoner on an open ACCT.
145. The governor and deputy governor both told us that they would have expected the manager in charge to have contacted the duty governor. This would have allowed some senior manager input and a broader perspective to have been taken. The deputy governor said she might have decided to ring the A&E doctor herself to speak directly to him about the man's safety before he discharged himself. She said she might also have sought help from HMP Norwich to see if they would have accepted him overnight into their inpatient healthcare unit which has 24 hour cover. As no one contacted the duty governor we cannot know whether this would have led to a different outcome for the man but it is important in such circumstances that prison staff seek advice from senior managers.

### **Monitoring the man on 5 October**

146. As noted, no one obtained the duty governor's approval to locate the man in the segregation unit when he returned from hospital in the early hours of 5 October. However, we are satisfied that this was a reasonable decision in the circumstances as he needed to be closely observed. It is unfortunate that the segregation unit was a part of the prison which did not allow smoking which caused the man further anxiety.
147. Soon after he returned to Blundeston, the man said he wanted to go back to the hospital. He reopened the wound on his left arm so that it bled again. The staff accounts at this point differ. The officer said the SO went to the segregation unit but decided not to send the man back to the hospital because "this would be the story for the rest of the night" if he did. The SO said he remembered being telephoned about the man opening up the wound on his arm, but that he did not go to the segregation unit to assess the situation. He said he was told there was only a small amount of blood and that his arm had stopped bleeding.
148. Whichever account is accurate, there is no dispute that the man had reopened the wound, yet he was not taken to hospital. Any further blood loss at that point was likely to be serious but none of the staff involved sought

medical advice about what to do. According to the ACCT record, the man fell asleep very shortly afterwards. We are very concerned that, taking into account the information that was available when the man was at hospital, he was not sent back to hospital when he lost further blood.

149. While it appears that the man was observed as required, we note that the OSG, an operational support grade, had been specifically based in the segregation unit to help the man monitor him. Despite this, he and the man agreed he could have an informal break from 3.00am to 5.00am. The two members of staff should have been together in the segregation unit so that they could both monitor the man (and the other two prisoners in there at the time). We are concerned that the OSG' absence from the segregation unit could potentially have compromised safety, but it appears that the required level of observations was completed.
150. A consultant in emergency medicine, provided a specialist report as part of the investigation. She noted that prison staff reviewed the man regularly but that the descriptions of his behaviour and complaints between 3.00am and 6.00am were compatible with someone who was continuing to lose blood and was developing severe hypovolaemic shock. These included symptoms such as light-headedness, inability to stand up on his own, feeling cold, wanting water and being unsteady on his feet. Shouting and screaming could also indicate the agitation of someone with increasingly severe hypovolaemic shock. His eventual silence represented the point at which the man was no longer able to compensate for the blood loss. This would have resulted in a further decline in blood pressure and cardiac output, culminating in cardio-respiratory arrest. The consultant notes that while these symptoms might have been apparent to clinicians they would not have been obvious to prison staff.
151. We accept that without briefing of what symptoms to look out for, the man and the OSG could not have been expected to know what was happening with the man. While it might not have been clearly evident to the two staff that there had been any medically significant changes we consider that they should have sought further advice after 3.00am when his presentation changed from earlier. However, the more significant omission remains that the man was not taken back to hospital when he first re-opened his wound.