

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Colin Blackburn, a prisoner at HMP Hewell, on 6 July 2019

A report by the Prisons and Probation Ombudsman

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*



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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 Colin Blackburn was found hanged in his cell at HMP Hewell on 6 July 2019. He was 53 years old. I offer my condolences to Mr Blackburn's family and friends.

Mr Blackburn was a vulnerable prisoner who often told staff he felt unsafe in prison. He was monitored under Prison Service suicide and self-harm prevention procedures (known as ACCT) throughout the two weeks he spent at Hewell. We found some serious failings in the way ACCT procedures were managed.

I am also not satisfied that the mental health care Mr Blackburn received in prison was equivalent to that which he could have expected to receive in the community.

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

Sue McAllister CB
Prisons and Probation Ombudsman

April 2020

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Summary

Events

1. Mr Colin Blackburn was on remand for a violent offence. When he arrived at HMP Hewell on 21 June 2019, he told prison officers that he felt under threat from his co-defendant and asked for vulnerable prisoner status.
2. Mr Blackburn had a history of anxiety and depression and staff managed him under suicide and self-harm prevention procedures known as ACCT throughout his two weeks at Hewell. He often refused food and self-isolated in his cell.
3. On 25 June, a prison officer found Mr Blackburn hanging in his cell and he was placed under constant supervision in the prison's inpatients unit.
4. On 28 June, a prison manager reduced Mr Blackburn's level of observations to five an hour and he was moved to another cell in the prison's inpatients unit.
5. On 2 July, Mr Blackburn tied a TV aerial around his neck in his cell. He told a prison officer that he was nervous about returning to the residential wing. An ACCT review did not take place and Mr Blackburn was moved to a standard residential wing. A few hours later, he placed a ligature around his neck again.
6. Mr Blackburn was moved to the vulnerable prisoner's unit on 4 July. He continued to say that he did not feel safe in prison and that he intended to take his own life. Prison staff assessed his risk as low and reduced his observations to three an hour.
7. On 5 July, staff noted that they were too busy to maintain the correct level of observations.
8. At 5.10pm on 6 July, an officer carrying out an ACCT check, found Mr Blackburn hanging from a ligature attached to his bed. Staff and paramedics tried to resuscitate Mr Blackburn, but at 6.00pm, it was confirmed that Mr Blackburn had died.

Findings

9. There were a number of failings in the management of ACCT procedures. Staff did not consider all of Mr Blackburn's triggers and risk factors when assessing his risk of suicide, and so did not set observation levels to reflect that risk. Observations were not always carried out in accordance with Mr Blackburn's ACCT plan.
10. Case reviews were not always multi-disciplinary, the ACCT caremap was not updated and reviewed at each case review and did not include specific actions to reduce Mr Blackburn's risk. ACCT reviews did not take place after an incident of self-harm and Mr Blackburn was moved to a wing for normal location prisoners despite his vulnerability.
11. The clinical reviewer concluded that the mental health care Mr Blackburn received at Hewell was not equivalent to that which he could have expected to receive in the community. Healthcare staff did not manage him appropriately in

view of his history of self-harm, and referrals to the mental health team were not always received or followed up.

12. When Mr Blackburn self-isolated, staff failed to apply the prison's Self-Seclusion Strategy.

Recommendations

- The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines. In particular, staff should:
 - hold multidisciplinary ACCT reviews which take place within the set timescales;
 - record and take into account all known risk factors and triggers at case reviews and set a level of observations which appropriately reflects that risk;
 - set effective caremap objectives which are specific, time-bound and meaningful, aimed at reducing risk and updated at each case review;
 - ensure prisoners are reviewed after an act of self-harm or an expression to commit self-harm;
 - ensure ACCT checks are completed within the set observation levels.
- The Governor should ensure that every prisoner receives a full induction.
- The Head of Healthcare and Mental Health Team manager should review the system for receiving and actioning TAG referrals to ensure they are processed appropriately.
- The Head of Healthcare and Mental Health Team manager should ensure that all interactions with prisoners who are subject to ACCT procedures are recorded in their electronic medical record.
- The Governor should ensure that prisoners who self-isolate are managed in accordance with the prison's strategy.
- The Governor and Head of Healthcare should ensure that staff complete a formal discharge before a prisoner is moved from the inpatients unit.
- The Governor should ensure that staff complete an ACCT review before a prisoner is moved to another location.
- The Governor and Head of Healthcare should ensure that staff monitor a prisoner who is refusing food in accordance with PSI 64/2011.

The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Hewell informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
14. The investigator visited Hewell on 11 July. She obtained copies of relevant extracts from Mr Blackburn's prison and medical records.
15. The investigator interviewed 17 members of staff at Hewell on 25 and 26 September and 10 October.
16. NHS England commissioned an independent clinical reviewer to review Mr Blackburn's clinical care at the prison. They jointly interviewed prison and healthcare staff.
17. We informed HM Coroner for Worcestershire of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
18. We wrote to Mr Blackburn's friend, his nominated next of kin, to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not respond to our letter.
19. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Hewell

20. 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 (where Mr Blackburn was held) is a secure, local prison. Care UK provide health services and there is a 20-bed inpatient unit.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Hewell was in June 2019. Inspectors reported that there had been a marked decline in the prison's performance since the last inspection. Hewell was graded as poor for safety for the third time and HM Chief Inspector of Prisons considered issuing an Urgent Notification (UN), requiring the Secretary of State to produce an action plan for improvement within 28 days. However, the Chief Inspector did not invoke the process because Hewell had already been in 'Special Measures' for some considerable time. The Chief Inspector, having reviewed the Special Measures Action Summary, concluded that it was highly unlikely the UN process would achieve the required improvements.
22. Inspectors found most prisoners spent too long in reception and the cell-sharing risk assessment was not always carried out in private. First night risk assessments were not always completed, putting prisoners at risk during their early days in custody. The delivery of the induction programmes was often delayed and weak, and management oversight of the process was poor. Not all staff working on the unit had received adequate training in first night procedures. Although most prisoners attended an induction, it was often delivered late and did not provide adequate or up-to-date information to new arrivals.
23. PPO recommendations following previous deaths in custody had not been fully implemented, and oversight of their progress was inadequate.
24. Inspectors found there was good local leadership of health services.

Independent Monitoring Board

25. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to September 2018, the IMB reported that staffing levels were insufficient to meet the needs of the prison. The Board considered that ACCT documents were completed satisfactorily.

Previous deaths at HMP Hewell

26. Mr Blackburn was the 15th prisoner to die at Hewell since July 2017. Of the previous deaths, three were self-inflicted, six were from natural causes, four were drug-related and one was a homicide. There has been one death from natural causes since Mr Blackburn's death. Our investigation into the other self-inflicted death, in May 2019, found that the prisoner did not receive a full induction.

Assessment, Care in Custody and Teamwork

27. 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.
28. 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.
29. 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

30. On 21 June 2019, Mr Colin Blackburn was remanded to HMP Hewell charged with wounding with intent to commit grievous bodily harm.
31. Mr Blackburn arrived at Hewell around 3.37pm. On his Person Escort Record (PER - a document that accompanies all prisoners when they move between police stations, courts and prisons which sets out the risks they pose) court staff recorded that Mr Blackburn's co-defendant had threatened him in the court room, and they were sent to Hewell separately.
32. An officer completed Mr Blackburn's cell sharing risk assessment (CRSA) and recorded that there were no issues which prevented Mr Blackburn from sharing a cell. Mr Blackburn told the officer that he felt suicidal and asked for vulnerable prisoner status because he had received threats from his co-defendant. Mr Blackburn was assessed as a standard risk to others and was allocated a double cell on house block 2, a vulnerable prisoners wing.
33. A nurse completed Mr Blackburn's initial health screen. He noted Mr Blackburn had a history of problems with drugs and alcohol and his urine tested positive for benzodiazepines (used to treat anxiety). The reception GP noted Mr Blackburn's history of depression and prescribed diazepam (for anxiety and alcohol withdrawal) and advised Mr Blackburn that his medications would be stopped if he took illicit substances.
34. At 6.00pm, the officer began ACCT procedures because Mr Blackburn said that he was feeling suicidal. At 6.10pm, a Supervising Officer (SO) completed Mr Blackburn's immediate action plan and placed him on one observation an hour. At 8.15pm, an ACCT entry said that Mr Blackburn was very worried about his safety because his co-defendant was also in Hewell and had threatened to make his life difficult.
35. At 12.00pm on 22 June, an officer carried out an ACCT assessment. Mr Blackburn said that he had thought about hanging himself and felt he had no other way out. The officer did not record the issues discussed on Mr Blackburn's caremap and did not record any triggers on his ACCT plan. The officer made an entry on Mr Blackburn's PNOMIS (prison electronic record) but did not complete the 'non-associations' section to ensure staff were aware that his co-defendant was also in Hewell and that they should be kept apart.
36. At 11.30am on 24 June, a SO completed the first case review. The assessment was not completed within 24 hours of ACCT procedures starting and was not multi-disciplinary. Mr Blackburn said he had not eaten since 19 June and wished to remain locked in his cell. Mr Blackburn's risk of suicide or self-harm was recorded as low and no issues were noted on his caremap.
37. On 25 June, a SO completed Mr Blackburn's basic custody screening. Mr Blackburn said he suffered from anxiety and depression and was feeling suicidal. He told the SO he would not have contact with family and friends while he was in prison. The officer noted that Mr Blackburn was currently managed by ACCT procedures but did not complete the section relating to self-harm and did not record his lack of family support as a risk factor on his ACCT plan. The same

day, an officer made an entry in Mr Blackburn's PNOMIS and said that Mr Blackburn was not offered a full induction because he was locked in his cell due to being under threat.

38. At approximately 12.55pm, prison staff found Mr Blackburn in his cell with a ligature round his neck. He did not require resuscitation. Mr Blackburn had written a note which identified a friend as his next of kin. A SO chaired an ACCT review, attended by a nurse, and noted that Mr Blackburn had said he was 'ready to go'. Mr Blackburn said he was innocent of his offence and felt he had nothing to live for. The SO assessed Mr Blackburn as a high risk of suicide and self-harm and recommended non-clinical constant supervision. (If staff consider a prisoner to be at very high risk of suicide or self-harm, they can implement constant supervision, which means the prisoner must be watched at all times.) The nurse completed an electronic TAG referral to the mental health team (a request for them to assess the severity of a prisoner's mental health problems and to identify if they should be referred to mental health services). At 1.30pm, Mr Blackburn was moved to a constant supervision cell in the prison's inpatients unit.
39. At 5.00pm, a nurse noted in Mr Blackburn's medical record that he said he had not eaten for five days and that he had refused his evening meal.
40. As Mr Blackburn was subject to constant supervision, a prison manager was assigned as his ACCT case manager. On 26 June, he chaired an ACCT case review, attended by a constant supervision officer and a prison chaplain. Mr Blackburn said he still had thoughts of self-harm and taking his own life. The case manager assessed Mr Blackburn's risk as high and decided he should remain under constant supervision. He reviewed Mr Blackburn's caremap and added one issue about Mr Blackburn's history of depression. The same day, a nurse noted in Mr Blackburn's medical record that he had told her he had an eating disorder. She noted that Mr Blackburn had refused all meals but was drinking fluids.
41. On 27 June, the case manager chaired an ACCT case review, attended by a nurse. He assessed Mr Blackburn's risk as unchanged. The same day, a multi-disciplinary team (MDT) meeting reviewed Mr Blackburn. A nurse noted the TAG referral to the mental health team and arranged to complete an assessment on 28 June.
42. During this assessment, a nurse noted that it was difficult to assess Mr Blackburn because he was behind a plastic screen due to being on constant supervision. Mr Blackburn said he had a history of depression and drug and alcohol abuse and denied taking illicit substances in prison. The nurse did not record this assessment in Mr Blackburn's electronic medical record.
43. On 28 June, the case manager chaired an ACCT case review, attended by a nurse. He noted that Mr Blackburn had said that if he was convicted, he intended to take his own life by cutting his throat. He decided to reduce Mr Blackburn's level of observations from constant supervision to five an hour. He noted that Mr Blackburn would return to the normal wing if there were no further issues. The same day, Mr Blackburn was moved to a cell in the prison's

inpatients unit. A Custodial Manager (CM) was assigned as Mr Blackburn's case manager.

44. On 30 June, Mr Blackburn told an officer that he was nervous about returning to the wing. The officer noted in Mr Blackburn's ACCT record that he appeared low in mood.
45. On 1 July, a nurse assessed Mr Blackburn and noted that his mood was low, his appetite was poor and he was worried about the outcome of his trial. The nurse discussed the assessment with a healthcare manager. They decided that Mr Blackburn did not need the support of the mental health team and could be managed by the safer custody team through ACCT procedures.
46. The same day, the case manager chaired an ACCT case review, attended by a nurse. He assessed Mr Blackburn's risk as low and reduced his observations to three an hour. He noted that Mr Blackburn said that he was in a much better place and wanted to return to the wing. He noted that Mr Blackburn would return to house block 5 (a vulnerable prisoner's wing) the next day.
47. We found no evidence that healthcare staff reviewed Mr Blackburn prior to his discharge from the inpatients unit.

Events of 2 July

48. At 7.10am on 2 July, Mr Blackburn rang his cell bell and an officer responded. He noted in Mr Blackburn's ACCT record that he had found Mr Blackburn with a ligature around his neck. Mr Blackburn was upset and protesting that he did not want to return to a normal location wing and wanted to return to house block 5. The officer used his anti-ligature knife to remove the ligature. He told the investigator that a nurse also went to Mr Blackburn's cell and reassured him that he would be moving to house block 5. The nurse told the investigator she could not remember if she went to Mr Blackburn's cell when an officer found him with a ligature around his neck and does not recall if she had told him he was moving to house block 5.
49. An officer attached a post-it note to Mr Blackburn's ACCT document which said, 'May need to be reviewed-attempted ligature.' We found no evidence that the officer discussed the incident with prison staff or Mr Blackburn's ACCT case manager. He did not make an entry in the wing observation book, Mr Blackburn's PNOMIS or complete a Mercury Intelligence Report (MIR).
50. Later that day, an acting prison manager asked three CMs to move Mr Blackburn to a cell on house block 6 (a wing for normal location prisoners). CCTV shows the CMs arriving at Mr Blackburn's cell at 5.02pm and leaving the inpatients unit at 5.10pm. We found no evidence that a review of Mr Blackburn's ACCT document took place before he was moved.
51. At approximately 9.40pm during an ACCT observation, an officer found Mr Blackburn with a ligature around his neck. The officer called an emergency code blue (to indicate a prisoner is unconscious or having breathing difficulties) and the control room called an ambulance. A CM responded and entered Mr Blackburn's cell. Mr Blackburn agreed to remove the ligature. A nurse attended and because Mr Blackburn was conscious and talking to a CM, she told the

control room that an ambulance was no longer needed. Mr Blackburn asked for support from the mental health team and the nurse completed a TAG referral. As the mental health team administrator did not process the referral correctly, the mental health team did not see Mr Blackburn before he died.

52. At 9.50pm, a CM chaired an ACCT case review, attended by a nurse. The CM assessed Mr Blackburn's risk of suicide and self-harm as low and increased his observations to five an hour. He noted that a further ACCT review would take place on 3 July. We found no evidence that this took place.
53. On 3 July, Mr Blackburn told prison staff that he was in danger on house block 6 and asked to move to house block 2 for his own protection. At approximately 8.15pm, Mr Blackburn passed a note under his cell door to an officer which said he was under threat from other prisoners. Mr Blackburn asked to move from house block 6 for his own safety.
54. On 4 July, entries in Mr Blackburn's ACCT record noted that he was becoming increasingly paranoid the more time he spent locked in his cell and that he believed other prisoners were conspiring against him.
55. Because Mr Blackburn's ACCT case manager was unavailable, a CM chaired an ACCT case review, attended by a SO. The review was not multi-disciplinary. The CM noted that Mr Blackburn was concerned for his own safety and wanted to remain locked in his cell. The CM assessed Mr Blackburn's risk of suicide and self-harm as low and reduced his observations to three an hour. Mr Blackburn said he was worried about his dog which was going to be destroyed if he could not find her another home, and the CM added this as an issue on Mr Blackburn's caremap. The SO added a TAG referral to Mr Blackburn's caremap but there is no evidence that this was received by the mental health team. The same day, Mr Blackburn was moved to a single cell on house block 2, a vulnerable prisoners wing.
56. At 8.15am on 5 July, an officer noted in Mr Blackburn's ACCT record that he did not feel safe in prison and was still considering taking his own life. The officer offered Mr Blackburn the opportunity to speak to a Listener (a prisoner trained by the Samaritans to support other prisoners) but he refused. The prison completed a management inquiry into this incident. The officer said that she spoke to Mr Blackburn's ACCT case manager, a CM and told her that she was concerned that Mr Blackburn intended to self-harm. She did not have access to PNOMIS and said she did not know that she should make an entry in the wing observation book. The CM told the investigator that she could remember the officer speaking to her about Mr Blackburn.
57. At 12.00pm, an entry in Mr Blackburn's ACCT record noted that prison staff were unable to maintain the level of his observations because they were so busy.

Events of 6 July

58. At approximately 4.45pm on 6 July, an officer completed an ACCT check and did not note any issues or concerns. CCTV shows the officer returning to Mr Blackburn's cell at 5.10pm and looking through the observation panel. He immediately went into Mr Blackburn's cell. The officer told the investigator he

saw Mr Blackburn hanging from a ligature attached to his bed and he used his anti-ligature knife to remove the ligature. A SO attended and radioed an emergency code blue. The control room immediately called an ambulance. The officer and SO started cardiopulmonary resuscitation (CPR).

59. At 5.28pm, the paramedics arrived and took control of Mr Blackburn's care. At 6.00pm, they confirmed that Mr Blackburn had died.

Contact with Mr Blackburn's family

60. The prison appointed a family liaison officer (FLO) and identified Mr Blackburn's friend as his next of kin. The FLO and a member of the prison chaplaincy team travelled to Mr Blackburn's friend's address to break the news of his death in person, but he was not there. When they returned to the prison, Mr Blackburn's friend contacted them by telephone and they broke the news of his death.
61. In line with Prison Service guidance, the prison paid for and arranged Mr Blackburn's funeral.

Support for prisoners and staff

62. After Mr Blackburn's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
63. The prison posted notices informing other prisoners of Mr Blackburn's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Blackburn's death.

Post-mortem report

64. The pathologist concluded that Mr Blackburn died from hanging. The toxicology report noted sertraline (an anti-depressant) and nordiazepam (to treat anxiety) in his blood but below limits which suggested prior use. Mr Blackburn was prescribed sertraline and nordiazepam during his time in custody.

Findings

Management of Mr Blackburn's risk of suicide and self-harm

65. Mr Blackburn was identified as a vulnerable prisoner when he arrived at Hewell and prison staff appropriately decided he should be managed under the ACCT suicide and self-harm prevention procedures.
66. Prison Service Instruction (PSI) 64/2011 on safer custody, requires all staff who have contact with prisoners to be aware of the triggers and risk factors that might increase the risk of suicide and self-harm, and take appropriate action. (The risk factors were also listed in our thematic report published in 2014.) Those that applied to Mr Blackburn included a history of mental health problems, lack of social support, violence, intimidation or fear of these, and court appearances, especially at the start of his trial and sentencing. We are concerned that prison staff did not record Mr Blackburn's triggers and risk factors on his ACCT document.
67. We consider that the ACCT procedures did not effectively support Mr Blackburn because the overall management of the ACCT was poor and not fully in line with PSI 64/2011. The initial case review was carried out three days after Mr Blackburn's ACCT document was opened and the ACCT case reviews were not always multi-disciplinary. The mental health team manager told the investigator that while prison staff provided a list of ACCT case reviews, they did not include times which made it difficult for healthcare staff to attend.
68. Caremaps should reflect the prisoner's needs, level of risk and the triggers of their distress. Instructions say they should aim to address issues identified in the ACCT assessment interview and later reviews, and consider a range of factors including health interventions, peer support, family contact and access to diversionary activities. Each action on the caremap should be tailored to the individual needs of the prisoner, be aimed at reducing risk and be time bound. We do not consider there were appropriate caremap actions aimed at reducing Mr Blackburn's risk.
69. We consider that Mr Blackburn's caremap was inadequate and contained no direct actions to address his food refusal and self-isolating behaviour. Although Mr Blackburn told prison staff he was under threat from other prisoners, staff did not identify this as an issue in Mr Blackburn's caremap and his caremap was not always reviewed at ACCT case reviews.
70. We are concerned that Mr Blackburn was not reviewed after acts of self-harm and his assessed level of risk did not always reflect his behaviour. In addition, prison staff did not always complete observations in accordance with his ACCT document because they were too busy. We consider that Hewell need to take urgent steps to improve the ACCT process. We recommend that:

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

- **hold multi-disciplinary ACCT reviews which take place within the set timescales;**

- **record and take into account all known risk factors and triggers at case reviews and set a level of observations which appropriately reflects that risk;**
- **set effective caremap objectives which are specific, time-bound and meaningful, aimed at reducing risk and updated at each case review;**
- **ensure prisoners are reviewed after an act of self-harm or an expression to commit self-harm;**
- **ensure ACCT checks are completed within the set observation levels.**

Induction

71. We found no evidence that Mr Blackburn received a first night interview at Hewell or that prison staff completed his third day of induction. We are concerned that Mr Blackburn did not receive a full, comprehensive induction at Hewell. This is an issue we have raised with Hewell before. We recommend that:

The Governor should ensure that every prisoner receives a full induction.

Mental health

72. Mr Blackburn had a history of depression but was not under the care of mental health services in the community. Mental health nurses at Hewell assessed Mr Blackburn after his first suicide attempt on 25 June and saw him while he was under constant supervision. Despite Mr Blackburn telling a nurse that his mood was low, his appetite poor and he was worried about the outcome of his offence, the mental health team manager and the nurse decided that Mr Blackburn did not need the support of the mental health team.
73. The nurse and the mental health team manager told the investigator that when he was assessed, Mr Blackburn had not displayed signs of depression and his focus was on his alleged offence. Neither had seen his suicide note. The nurse said she planned to see Mr Blackburn again, but as no further TAG referrals were received, she did not see him before he died.
74. Mr Blackburn placed a ligature around his neck on two occasions on 2 July. The first was not reported to Mr Blackburn's ACCT manager by an officer and a nurse denied seeing him in his cell. (There is no record in Mr Blackburn's electronic medical record that a nurse saw him and she could not explain why an officer said she had reassured Mr Blackburn in his cell.) As a result, the incident was not known to prison staff when Mr Blackburn self-harmed again later that day. On this occasion, Mr Blackburn asked for the support of the mental health team, but the TAG referral was not processed. A third TAG referral was made on 3 July but it is unclear if this was received by the mental health team.
75. The clinical reviewer concluded that Mr Blackburn mental health care was not equivalent to that which he could have expected to receive in the community. Mr Blackburn was managed on the lowest tier of the Stepped Care model (Stepped Care comprises of 5 tiers of severity of mental illness from mild to severe. Tier 1 is usually manageable by GP input) which the clinical reviewer considered inappropriate in view of his history of self-harm. The clinical reviewer also found that record keeping was not of an acceptable standard. We recommend that:

The Head of Healthcare and Mental Health Team manager should review the system for receiving and actioning TAG referrals to ensure they are processed appropriately.

The Head of Healthcare and Mental Health Team manager should ensure that all interactions with prisoners who are subject to ACCT procedures are recorded in their electronic medical record.

Self-Seclusion Strategy

76. Hewell did not follow its own Isolating Individuals Strategy (published in 2017 and currently under revision) when Mr Blackburn began self-isolating. The strategy says prisoners identified as self-isolating for longer than 24 hours should be referred to safer custody, investigated and interviewed by the residential custodial manager to understand why the prisoner is self-isolating, to seek a possible solution and to signpost to other support. We found no evidence that the safer custody team was made aware that Mr Blackburn was self-isolating or that he was interviewed by the residential CM.
77. Mr Blackburn was first identified as a self-isolator on 24 June. When he was moved to house block 6 on 2 July, he told prison staff he wanted to remain locked in his cell because he was under threat from other prisoners. We recommend that:

The Governor should ensure that prisoners who self-isolate are managed in accordance with the prison's strategy.

Mr Blackburn's location

78. When Mr Blackburn arrived at Hewell he requested vulnerable prisoner status and was allocated a cell on house block 2, a wing for vulnerable prisoners. After he came off constant supervision, his case manager assured Mr Blackburn that he would return to a vulnerable prisoner wing (house block 5). Despite this, an acting prison manager made the decision to move Mr Blackburn to house block 6, a wing for normal location prisoners.
79. The case manager told the investigator he did not know the decision to move Mr Blackburn. He was also unaware that Mr Blackburn had expressed concern about his move from the inpatients unit and that Mr Blackburn had self-harmed in the inpatients unit on 2 July. He told the investigator he would not have authorised his move from the inpatients unit if prison staff had told him. The acting prison manager told the investigator that he could not recall who asked him to arrange Mr Blackburn's move from the inpatients unit to house block 6. He said he did not check Mr Blackburn's ACCT document to ensure that the move was appropriate.
80. We found no evidence that healthcare staff completed a formal discharge before Mr Blackburn was moved from the inpatients unit. The failure of prison staff to review Mr Blackburn's ACCT document prior to his move to house block 6 meant that staff were unaware that Mr Blackburn was distressed about his move from the inpatients unit. As a result, Mr Blackburn, a vulnerable prisoner who had

recently been under constant supervision, was moved to a clearly unsuitable location. We recommend that:

The Governor and Head of Healthcare should ensure that healthcare staff complete a formal discharge before a prisoner is moved from the inpatients unit.

The Governor should ensure that staff complete an ACCT review before a prisoner is moved to another location.

Management of Mr Blackburn's food refusal

81. Mr Blackburn told prison staff he had not eaten for six days during his first ACCT case review on 24 June. While he was under constant supervision, prison nurses noted in his medical record that he was not eating but was drinking fluids. Chapter 10 of PSI 64/2011, *Management of prisoners who refuse food and/or fluids and medical treatment*, says that food and fluid refusal is not considered in law to be a form of self-harm, but that an ACCT may provide a useful way of recording the care offered and facilitate information sharing. PSI 11/2012, *Incident Reporting*, says food refusal should be reported to the National Operations Unit (NOU) after 72 hours.
82. Guidance from the Department of Health says it is critical that a thorough assessment of a person's mental capacity and nutritional status is undertaken immediately and there should be regular reassessments of the person's physical and mental state.
83. Despite Mr Blackburn not eating for a period longer than three days, prison and healthcare staff did not start a food refusal log or create a food and fluid care plan to monitor his nutritional needs. Mr Blackburn's food refusal was not included as an issue on his care map. We recommend that:

The Governor and Head of Healthcare should ensure that staff monitor a prisoner who is refusing food in accordance with PSI 64/2011.

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