

**Investigation into the circumstances surrounding the
death of a man
at HMP Blakenhurst in July 2004**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

August 2005

This is the report of an investigation into the circumstances surrounding the death of a man at HMP Blakenhurst in July 2004.

The investigation was conducted under the terms of the transitional arrangements agreed between my office and the Prison Service, which came into effect on 1 April 2004. The bulk of the investigative work has been conducted on my behalf by a Senior Investigating Officer (the SIO) at the Prison Service's West Midlands Area Office. The SIO was assisted by a Principal Officer (PO) from HMP Blakenhurst. A review of the man's detoxification programme at Blakenhurst was conducted by the Section Head of Substance Misuse at Prison Health. I am grateful to all members of the team for their work.

An investigator from my office liaised with the SIO during this investigation.

I have structured this report so that the SIO's investigation can be separately identified. It has been subject only to minor editing.

During the investigation, the SIO and my investigator met the man's parents and his sister. I know they offered their sympathy and condolences. I would like to take this opportunity to add my own condolences to the man's parents, his sister and his friends.

I should record here my thanks to the Governor of Blakenhurst and his staff for the help the investigators received during the investigation. All staff co-operated fully and readily with the inquiry.

Before he died, the man wrote a letter to his family. This indicates some of what was in his mind on the night of 28 July. What it does not show is the extent to which his mood was affected by detoxification from methadone. The clinical review commissioned as part of this investigation judges that the detoxification regime was inappropriate. Although the investigator's report contains no formal recommendation on the point, I ask the National Offender Management Service's Safer Custody Group, and Prison Health, to draw to the attention of prison healthcare professionals the issues raised by this investigation.

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Prisons and Probation Ombudsman

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SUMMARY

The man was 28 years old when he was received at Blakenhurst on 22 July 2004. He had many convictions, largely for comparatively minor offences, dating back to the early 1990s. The man had served time in a number of prisons, including Blakenhurst.

During his first reception health screen at Blakenhurst on 22 July, the man reported that he had no history of mental health problems, that he had never harmed himself and that he had no thoughts of self-harm. The man also reported having no physical health problems, but did report that he was a daily user of methadone. The man was allocated to a double cell containing a bunk bed. The man took the top bunk and his cell-mate took the bottom bunk.

In a follow-up consultation with a healthcare doctor on 23 July, the man was recorded as saying that he was a heroin addict and was experiencing withdrawal symptoms. He was started on a detoxification programme consisting of diazepam, supplemented by three other drugs for symptom relief.

Over the course of his first three days in the establishment, the man underwent induction. An entry was made in the man's records on 23 July that he had been continually disruptive during induction that day. Apart from that, nothing else seems to have occurred around the man's behaviour or demeanour to cause staff any concern on matters of discipline or in connection with the man's personal well being.

It emerged during the interviews with other prisoners that the man had made comments to suggest he might self-harm. However, the prisoners to whom the man made these remarks did not take him seriously, or mention anything to staff, as the man subsequently turned his remarks into jokes.

Comments made by another prisoner suggest that the man might have been in a great deal of pain stemming from his drug withdrawal and that he was refused help when he approached staff, presumably healthcare staff, at the treatment hatch. There is no evidence from any other source to corroborate this prisoner's comments and the man's clinical records confirm that he received all his prescribed medication.

The evidence of the man's cell-mate was that he fell asleep at around midnight on the night of 27 July. At that point the man had been writing a letter. Nothing had occurred earlier that evening for the cell-mate to have any concern over the man's well being. The cell-mate woke in the early hours of 28 July, as he needed to use the toilet. When he got out of bed he saw that the man had hanged himself using a ligature tied to the upper bunk of the bed. The cell-mate alerted staff, but attempts to resuscitate the man proved unsuccessful.

The letter that the man had been writing the previous night, which was addressed to his family, was found by staff after they were alerted to it by the

cell-mate. In this letter, the man spoke of his regret for the things he had done, for the action he was going to take, and asked for God's forgiveness.

This report makes a number of recommendations. The most significant relate to processes for dealing with people who declare drug misuse, including the inappropriateness of diazepam for opioid detoxification. Other recommendations deal with a range of matters including staff training needs.

SENIOR INVESTIGATING OFFICER'S REPORT

I would first like to offer my condolences to the man's family and friends. The death of anyone close is always difficult.

I would like to thank everyone who worked in contributing to this report. This includes everyone who supplied the evidence that underpins the report, those who contributed to its writing and production as well as outside agencies.

Investigative process

The Terms of Reference established the boundaries of the investigation. To fulfil these an appropriately qualified team was appointed. I have received the training necessary to fulfil the role of Senior Investigating Officer for the Prison Service and have conducted many investigations including four deaths in custody in the last two years. I currently work as Regional Resettlement Manager. My last operational role was at HMYOI Onley as Deputy Governor.

Evidence Gathering and Analysis

The investigation team used Prison Service Order 1301 as the principal document for the investigation. The first steps for the investigating team were to make contact with the liaison officer at Blakenhurst, with the police officer leading the police inquiry, and with the Coroner's officer to distribute the terms of reference and establish lines of communication.

Ensuring that the Prison Service investigation did not interfere with or displace the primacy of the Police investigation, the investigation team visited Blakenhurst to collect and collate documentary evidence. The aim was also to meet with relevant parties, principally the Governor, the liaison officer and any relevant trades union representative and to view the site so as to better understand the incident.

Following the collection and analysis of the documentary evidence relating to the man, the events surrounding his death, and Blakenhurst's policies and procedures and relevant police statements, a list of key persons to interview was drawn up. These interviews, the transcripts of which are included as appendices to this report, provided further information or clarification of issues that had arisen during analysis of the documentary evidence. They also led the investigation team to request further documentary evidence.

All the evidence gathered was analysed, sifted and structured to meet the Terms of Reference and is set out in this report.

The investigation team has no reason to believe that any information has been withheld. Every member of staff with whom an interview was requested co-operated and appeared to give full and frank answers. Every prisoner and

member of staff at Blakenhurst was also given the opportunity to contact the investigation team through display of investigation notices.

It was not possible to interview all the people initially identified by the investigation team. This was as a result of prisoners being released and the investigation team being unable to contact them. The potential limitations of this were mitigated by the extensive information and evidence gathering exercise conducted by the local police authority. As such, the investigation team is satisfied that there are no significant limitations to the investigation.

It has not been possible for every transcript completed to be confirmed as accurate by the interviewee as in some cases the addresses given appear to be inaccurate or individuals have not responded as requested. This does not apply to any staff witnesses and all the interviews in question generally support and supplement formal witness statements given to the police.

Every death in prison custody is treated initially as suspicious by the police officer attending the scene. An unusual factor in this case was that when he was found hanging, the man's hands were bound in front of his body and his feet were also bound. Police officers interviewed the man's cell-mate, in addition to interviewing other prisoners and staff. The police investigation is founded on the premise that the man's death was self-inflicted. Prior to this report being finalised, I met with the officers leading the police inquiry to confirm that there were no significant omissions in the evidence gathered for this investigation and that the initial assessments of cause of death, for example, had not changed.

HMP Blakenhurst

HMP Blakenhurst is located on the outskirts of Redditch in Worcestershire. It is a local prison, serving a number of courts in the West Midlands area. It opened in 1993 as a privately managed prison before becoming part of the public sector in the spring of 2001. At that time, a number of the existing staff transferred to the Prison Service and remained at Blakenhurst. However most of the posts within senior management team were filled by existing Prison Service staff.

In September 2003, Blakenhurst had an operational capacity of 856 adult males held principally within four identical houseblocks. Each houseblock has three spurs with cells on three levels. Most prisoners are held in double cells with separate specialist units including the Healthcare centre and a segregation unit. Roughly a third of the population are unsentenced remand prisoners.

The Events Leading up to the man's Death

The man's Prisoner Escort Record (PER) shows that he arrived at Blakenhurst at 7.22pm on 22 July 2004. The only risk identified on the PER form was a potential escape risk based on a comment made by the man to a police officer on or before 21 July. No reference was made on the PER form of the man having drug issues or being at risk of suicide or risk of deliberate self-harm.

The man was interviewed and assessed, according to his prison record (F2050), by a member of the healthcare team and by discipline staff. During his healthcare interview, the man disclosed that he was an intravenous drug user who had seen his GP in the previous few months for a methadone prescription, which the man said he took daily, the last time being two days before. The man also reported that he had been in custody at Blakenhurst in 2003, had no history of mental, physical illness or deliberate self-harm, and had no feelings of wishing to hurt himself at that time. In the 'Planned Action' section of the First Reception Health Screen form, a hand-written note '*Declined Detox*' was crossed through, and '*Changed mind*' written next to the original entry. The man was referred to a doctor.

In his interview with discipline staff, the man again disclosed that he had abused drugs, but there were no other indicators that the man presented a risk to himself or others.

Following these assessments, the man was located in cell C2-29 in houseblock two, which houses the induction unit. This was a double cell with a bunk bed. The man took the top bunk and his cell-mate took the bottom bunk.

On 23 July, documentary evidence (form F20550B) indicates that the man completed his day one induction. The Induction Officer indicated by completion of tick boxes that the man had, among other things, been issued an induction pack, and had been interviewed or addressed by staff from the CARATS drugs services team, NACRO, Probation and Chaplaincy teams. The man was also seen by a healthcare doctor on 23 July who noted his Inmate Medical Record (IMR) that: '*He is [a] heroin addict and is [on] methadone. Has withdrawal symptoms, has stomach cramps, vomiting [and] leg pains. Detox.*' The doctor prescribed a detoxification programme for the treatment of his opiate withdrawal which comprised of a seven day programme of diazepam, supplemented by a five day programme of symptomatic drugs: buscopan, loperomide and ibuprofen. The man's prescription chart shows that he took this medication three times daily, up to and including the evening of 27 July.

The man's prison record (F2050) also indicates that he underwent further induction on days two and three, including gymnasium induction. A separate PE department form ('Initial Assessment Induction Contribution Form') was also completed, with 'CARAT (drug services) Gym – Heroin Addict' entered as

a final summary of the man's targets and future development through physical education.

No documentary evidence has been found to indicate that the man either indicated to staff, or was perceived by staff, to be at risk of suicide or deliberate self-harm. The only explicit reference in the F2050 form to the man's behaviour in custody is on 23 July where it is stated: *'During 1st day inductions [the man] showed a 'know it all attitude' and was continually disruptive.'*

Evidence gathered from prisoners and staff after the man's death also offers relatively little evidence that he was at risk of suicide or deliberate self-harm. One prisoner (the man's friend) told the police that he had known the man since a child. The man told him on his second day at Blakenhurst that he had started making something to hang himself with, but that he had changed his mind (it does not seem that this information was shared with staff). The man's friend appears to have concluded that he was a bit down about the prospect of spending a long time in prison and the lack of contact with his family. However, they had discussed all these issues in detail and the man seemed positive and cheerful about things generally. The man's friend said that he was closer to the man than anyone else in the prison and he would have thought that he would have told him if he was going to take his own life.

A prisoner who shared a cell with the man's friend up to 23 July, wrote in his statement to the police that he had spoken with the man on either 22 or 23 July. The man had seemed shocked at being in prison, but gave no signs of being likely to self-harm. At a prisoners' focus group meeting on 20 August, this prisoner was reported as having said that he told a member of staff that the man was at risk of self-harm, but the officer had dismissed that information. When interviewed for this investigation, he said that he asked an officer to arrange for the man and his friend to share a cell as they had been friends for many years. The officer said that he would see what he could do, but the man was never moved into a cell with his friend. The friend's cell-mate was unable to name the officer or describe him in any way.

The man's cell-mate said that the man sometimes talked about hurting himself, but on each occasion he turned it into a joke and it was accepted as such by the cell-mate. Again, there is no evidence that any of this was relayed to staff. The cell-mate was also receiving detoxification medication.

A prisoner who arrived at Blakenhurst on 24 July, says that he was located in cell C2-38, opposite to C2-29. The prisoner from cell C2-38 saw and spoke to both the man and his cell-mate. In his statement to the police, and when subsequently questioned by the investigation team, he said that he saw an older prisoner with grey hair writhing in agony. He would have his arms wrapped about his stomach and would rock back and forth moaning. It looked like he was coming off drugs. The prisoner from cell C2-38 described seeing the same person at 6pm on 27 July appearing to be in pain. He advised him to seek medical help which he did by going to the treatment hatch. The prisoner asked for assistance but staff told him to go away. The prisoner from

cell C2-38 asked this prisoner for a match and was given one before being locked in his cell for the night. In an interview for this investigation, the prisoner from cell C2-38 was not able to describe the two men in the cell but was able to identify the man and his cell-mate when shown photographs. He said he thought the prisoner with stomach pains was the man subject to this investigation. He also described a number of conversations about withdrawal symptoms based on his own experiences. The prisoner from cell C2-38 said he spoke to at least one other prisoner, an Asian prisoner, whom he asked to keep an eye on the man with stomach pains.

When questioned about whether he thought the man was at risk of suicide or self-harm, the prisoner from cell c2-38 replied: *'No, I got a light off him before bang up. He said see you in the morning.'*

Other prisoners interviewed do not recall the man as withdrawing from drugs. Indeed one contradicts this entirely: *'... he wasn't smoking nothing. He wasn't withdrawing. He was offered and didn't take it. He wanted to get off it.'*

The most noticeable theme in all the responses collected after the man's death centre around him asking for or giving matches. The majority of the prisoners mention.

Two prisoners who shared a cell, also make reference to the man and his cell-mate shouting abuse and receiving abuse from prisoners on another spur of the houseblock on the evening/night of 27 July.

No-one interviewed who saw the man in the days or hours before his death give any indication that he was at risk of suicide or self-harm other than the man's friend and the man's cell-mate. Neither of whom said anything to staff. Two other prisoners said that the man was always laughing and joking and was: *'... a happy chap laughing and joking, no cause for concern.'*

The OSG said that she performed a security roll check shortly after she came on duty on the evening of 27 July. During this roll check she looked into every cell and accounted for every prisoner, including the man. She also recalls that she attended the cell and spoke with the man's cell-mate as a result of him pressing the cell bell as he had wanted a light for a cigarette. The OSG recalls nothing about her earlier contacts with the man or his cell-mate that made her think anything was wrong, nor had she received any instruction upon handover to pay any particular attention or carry out any special watch for them.

There is no evidence to suggest that anyone else either entered or looked into the cell from the point at which the OSG responded to the cell-mate's request for a light until he pressed the cell bell to alert staff at around 2.30am.

The cell-mate, at interview, recalls: *'... I must have fell asleep, I can't remember the time. It was pretty late and by that time [the man] was writing a letter, he was still writing a letter either watching TV and writing a letter and he was all normal ... so I must have fell asleep sometime after 12 around that*

time. The cell-mate also states that the man had asked him to post a letter if he awoke sooner than him the next morning. The cell-mate told staff of this after the man's death and the letter, which was addressed to his family, was found. This letter, which appears within the appendices attached to this report, commences with the words: *'I'm sorry that I took this way out but I can't see a future for me anymore ...'*

The cell-mate states that, prior to going to sleep, he took both prescribed medication and unprescribed medication that he had illicitly bought from other prisoners to help him sleep. These drugs, in combination with his self-reported lack of sleep caused by his own withdrawal from drugs, are the reasons he gives as to why he heard or saw nothing until he woke to discover the man hanging.

The OSG responded to the cell bell rung at around 2.30am on 28 July. She stated in interview: *'... I got a cell call C spur, I went to the cell, his cell mate stood by the hatch, he pointed to the corner by the bed and told me to look, at which point I saw inmate hanging from the side of the bed.'* The OSG, who was not carrying keys, called for assistance by radio and a 'code yellow' message was transmitted (a 'code yellow' indicates the need for urgent medical attention). As well as sending the radio message, the OSG also shouted for assistance.

The Night Orderly Officer (NOO), and the Night Officer were already in houseblock two in response to another incident. The NOO and the Night Officer heard the OSG call for help. They entered the cell and the NOO reports that she: *'Grabbed [the man's] legs and supported his weight and [the Night Officer] cut him down and put him on the floor.'* The Night Officer reports that he used his prison issue anti-ligature knife to cut the ligature between the bed and the man's neck. The man was placed on the floor on his side and the ligature was cut from his neck by the Night Officer, who also cut torn sheets that were binding the man's hands and feet. The NOO and the Night Officer recollect that they believe they felt the man breathing and the NOO recalls that: *'[The Night Officer] was sure he felt a pulse.'* Both staff thought the man was alive at that point. They placed the man in the recovery position and the NOO talked to him and rubbed his back, hoping that this would aid his breathing. After a while, the NOO said to the Night Officer that the man did not look right and that they would have to start CPR (cardiopulmonary resuscitation). At that point, the Night Nurse arrived.

The Night Nurse said that, at 2.30am on 28 July, she heard a code yellow call indicating that a serious medical incident had occurred. She gathered together emergency equipment, and she then waited for a prison officer to collect her and to escort her to where the incident was taking place. She needed an escort as nurses do not carry keys at night for security reasons. The Night Nurse arrived at the scene approximately five minutes after the code yellow alert had been issued.

The Night Nurse describes what she saw and what happened next. *'... [The man] was lying in the recovery position when I arrived. He didn't respond to*

me talking and shouting at him. Neither did he respond when I shook him and I checked for breathing which was absent. I immediately asked the officers to make a 999 call and we commenced CPR (cardiopulmonary resuscitation) immediately. I turned him over onto his back, I inserted an airway and mask and [the NOO] commenced chest compressions, ratio of 2 breaths, 5 compressions and pulse was absent so I instructed the two remaining officers to get me oxygen from the office in houseblock, which they connected for me, and then we changed the pocket mask to ambubag which had oxygen. I was still checking and there was no pulse. I asked [an officer] to take over with the ambubag and [the NOO] to continue with chest compressions while I applied the [defibrillator] pads to his chest, which I did so and the machine instructed me not to shock but continue with CPR which we did. A couple of times I did ask somebody to radio through ... to have an ETA (estimated time of arrival) on the ambulance and I was told it was just on its way. And I phoned them to inform the paramedics that the inmate was not breathing. Continued with CPR until it was about 2.50am and continued to follow the [defibrillator] instructions which was saying not to shock. Continued with CPR upon arrival of Officer and paramedic. I briefed him of the situation. He then attached his [defibrillator] and it was also telling not to shock, continued with CPR. Approximately 2.55am, 2.54am the paramedic asked if we were all in agreement to stop, there was no pulse, pupils fixed and dilated. The paramedic then pronounced him dead.'

The Night Nurse and other staff recall that emergency equipment was either brought to the scene from the Healthcare Centre and that this took approximately 5 minutes from the alarm being raised, or was collected by staff from the house-block where it was readily accessible.

The man's cell-mate was taken from the cell and located him in another cell where he was left alone. Two officers collected emergency equipment from the house-block and were then deployed to admit and escort the paramedics into the prison.

At approximately 4.25am, a doctor pronounced the man to be dead.

After the man's death

The incident log states that CPR stopped at approximately 2.54am, that by 3.25am the paramedics had removed their equipment and left the cell, and that a Governor sealed the cell at approximately 3.43am. The incident log also shows that the first police officers arrived on scene at approximately 3.48am. Undertakers removed the man's body at approximately 12.30pm. Police evidence gathering continued until approximately 1.00pm. A police family liaison officer and a prison chaplain visited the man's mother.

Support was offered to all staff directly involved immediately after the event. There is a record of a formal hot debrief. Support was also offered to the man's cell-mate by staff immediately on the scene and also by a Listener. In interview, the cell-mate seemed grateful for the support given by staff. There is, however, little to suggest that support for the cell-mate was well co-ordinated with the need for evidence gathering and preservation of evidence.

A detective inspector told me that he and his colleagues only became aware that the man's hands and feet had been tied several hours after the incident. The nature and sequencing of evidence gathering by the police would have been significantly different had this been known earlier. The detective inspector informed me that, in this case, he did not believe the delay caused critical evidence to be lost, but it did not help the police enquiry.

Level of Compliance with Prison Service Requirments

Contingency Plans

Contingency plans at Blakenhurst comply with Prison Service national policy.

Suicide Prevention and Strategy

When the Prison Service's internal audit group, the Standards Audit Group, last visited HMP Blakenhurst it rated the prison's auditable suicide prevention work as 'Acceptable'.

The aspirations and goals set out in Chapter 2, 'Early Period in Custody' and Annex 3 'Detox/First Night Overview', of the local suicide/self-harm strategy document, agreed by the Governor on 7 July 2004 and ratified by the Area Manager on 12 July 2004, had not been met in full at the time of the man's admission into HMP Blakenhurst.

Findings

The man entered prison custody on 22 July from Walsall Magistrates Court. The Prisoner Escort Record did not indicate that the man was at risk of suicide or deliberate self-harm or that there were drugs issues.

There is no evidence to suggest that the man expressed any direct threats of suicide or self-harm to members of staff while in custody. When asked directly about thoughts of suicide or self-harm, the man denied any such thoughts or feelings and he reported that he had no history of self-harm.

The man was not being monitored as being at risk of suicide or deliberate self-harm using F2052SH procedures at the time of his death.

There is evidence to suggest that the man talked about hanging himself with two other prisoners on separate occasions between 22 and 28 July. Neither of them believed that the man was at immediate risk of suicide or self-harm. There is no evidence to suggest that this information was disclosed to staff.

The man's drug misuse was disclosed to prison staff and he was prescribed medication for opioid detoxification. The clinical review prepared as part of this investigation sets out the basis on which this treatment was prescribed, setting the man's drug use in context, and commenting on the appropriateness of the treatment for him.

There is contradictory evidence about whether the man was in pain and discomfort. It is commented on by two prisoners and is not commented on by any other prisoners who knew or who remembered the man.

There is no evidence to indicate that the man was being bullied or had been threatened while in custody.

The man was found by his cell-mate suspended from a piece of torn sheet from the bunk bed frame of cell C2-29. The cell-mate pressed the cell bell for assistance sometime between 2.20am and 2.30am.

The OSG responded to the cell bell and, recognising the gravity of the situation, sought assistance.

The NOO and the Night Officer were on house-block 2 as a result of an earlier incident. They immediately intervened. The NOO supported the man while the Night Officer cut the ligature. Because the officers believed they had detected a pulse and breathing, they placed the man in the recovery position after they had removed the ligature from his neck and cut bindings from his hands and feet.

Very shortly afterwards, other staff arrived including the Night Nurse. She could not detect any vital signs so ordered that a 999 call be made for an ambulance to be summoned and she started resuscitation with the NOO.

Blakenhurst's contingency plans are silent on when it is appropriate to summon the emergency services.

The cell-mate was relocated to the crisis suite. Two officers brought additional emergency equipment. Another officer took part in the attempts to resuscitate the man.

At approximately 2.50am, paramedics arrived and checked the man as attempts at resuscitation were continuing.

At approximately 2.54am, CPR was stopped at the paramedics' instigation.

At approximately 4.35am a doctor pronounced death.

Information that the man's hands and feet had been tied was not passed to the police for several hours after the police investigation started.

A letter from the man to his family was found at the scene. Staff were directed to this by the man's cell-mate.

There seems to have been little heed paid to preserving the scene as a potential crime scene in the immediate aftermath of the incident. Those first on scene appeared to have received little training about the need for preservation of evidence.

Post-incident support was offered to those directly involved in the incident. There is a record of a formal hot debrief.

Contact was established with the man's mother. A prison chaplain visited the man's family, together with a police family liaison officer.

Conclusions

There was no delay in summoning assistance once staff identified that the man was hanging.

Those first on scene acted quickly and to the best of their ability to save the man's life.

The Night Nurse and additional emergency equipment arrived at the scene about five minutes after the code yellow call was issued. She ordered that a 999 call be made to the emergency services.

The man was not being monitored as being at risk of suicide or deliberate self-harm at the time of his death or at any point in custody.

Assessments of the likelihood of the man being at risk of suicide or self-harm were made on his entry into prison custody. These assessments appear to have relied on information given by the man and by direct observation by those making the assessments. The man's GP was not contacted to discuss his reported methadone prescription.

The man appears to have given no direct indication to staff that he was at risk of suicide or self-harm.

The man indicated to two other prisoners that he was considering suicide or self-harm. No evidence has been found to indicate that this was passed on to staff.

It is unlikely that the man was under any direct threat or pressure from others.

The man had a history of drug misuse, which was not ignored when he was received into prison custody. Conclusions about the appropriateness of his treatment are set out in the clinical report commissioned for this investigation and included in the annexes.

The immediate co-ordination of the scene to preserve evidence after resuscitation had stopped was poor. This appears to be the result of the inexperience and lack of training for those first on scene and in charge of the incident.

Communication between those first on scene and immediately in charge of the incident, and those coming to relieve them, appears limited insofar as key pieces of information such as the man's hands and feet being tied were not communicated. This appears to be the result of inexperience and lack of training for those first on scene and in charge of the incident.

Local recommendations

Blakenhurst's instructions, guidance and training on identifying the risk of suicide or deliberate self-harm upon reception should be reviewed to ensure that, in each case, not only is the conclusion of the assessment recorded where the individual is not considered at risk of suicide or self-harm but also:

The basis on which decisions are made including the weighting given to any background issues such as drugs misuse and withdrawal;

The evidence considered by the assessor.

Blakenhurst's contingency plans should include an instruction that a 999 call to the ambulance service be made immediately when a medical emergency is discovered.

No staff should perform the role of NOO without having received local contingency planning training. The functional leads for safer custody and security should satisfy themselves that all staff who act as NOO are able to meet all elements of the role.

Blakenhurst's Suicide/Self-Harm Prevention Strategy document should be reviewed to ensure that future aims and aspirations are clearly separated from procedures currently in force.

The content and frequency of local contingency planning training should be reviewed so that staff working at night receive regular training, including first aid training, and have received some specific training with regard to local contingency plans.

Local recommendations relating to the man's clinical care

Urine testing should be carried out on all received prisoners who declare recent drug misuse.

Specialist substance misuse nurse assessment and follow-up should be made available to all prisoners with an identified and active drug problem.

The continuation of a community methadone programme should be discussed with the prescribing doctor and the patient.

Diazepam should not be used for opioid detoxification.

In view of the more protracted withdrawal syndrome associated with methadone, detoxification regimes should be of at least 14 days' duration for patients dependent on this drug (ref National Treatment Agency 2003).