Investigation into the circumstances surrounding the death of a prisoner at HMP Blakenhurst in January 2006

Report by the Prisons and Probation Ombudsman for England and Wales

October 2006

This is the report of an investigation into the circumstances of the death of a prisoner who died in his cell at HMP Blakenhurst in January 2006. Following post mortem examination, the cause of the man's death was recorded as hanging.

I extend my sincere condolences to the man's family and friends.

The man who is the subject of this report had been in prison for approximately two months, having been remanded to HMP Blakenhurst on 17 November 2005.

I would like to thank the Governor of Blakenhurst at the time of our investigation. I am also grateful to those members of his staff who assisted us, particularly the senior officer who acted as a liaison officer for the investigation team. I have found the prison's efforts in liaising with the man's family to have been both sensitive and respectful.

I am also grateful to Redditch and Bromsgrove Primary Care Trust for their clinical review of the man's medical care whilst he was at Blakenhurst. The findings of the clinical review have informed this report.

With the benefit of hindsight, it is possible to argue that staff should have implemented the Prison Service's formal suicide and self harm prevention procedures (ACCT) in respect of this man. However, in facing serious charges and a breakdown in his personal relationships, and exhibiting signs of depression, the man did not appear to be so different from a very large number of prisoners in the Prison Service's care. Not all the relevant information was in one person's hands, but even if it had been I do not think one can say with certainty that an ACCT form would have been opened. Generally speaking, the staff at Blakenhurst have emerged well from this report and I do not believe the decision not to open an ACCT can be criticised - notwithstanding the tragedy that actually occurred.

I make three recommendations and draw a number of other matters to the Governor's attention.

Stephen Shaw CBE
Prisons and Probation Ombudsman **October 2006**

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Summary

1. The man who is the subject of this report was remanded to the custody of HMP Blakenhurst on 17 November 2005. He was facing two charges involving serious sexual offences.

2. On his arrival at the prison the man was given Rule 45 protection, meaning that he would be located on a wing for prisoners who might be vulnerable to attack by others. He spent his first night in the Segregation Unit and was located in a shared cell on a houseblock the following day.

3. Both a first reception health screen and a secondary health screen were carried out for the man on his first day at the prison, as was a cell sharing risk assessment. The health assessments raised no issues of concern regarding his physical or mental health.

4. The man was seen by a prison doctor on 5 December when he described feeling depressed and low. He was prescribed anti-depressants for 14 days. On 11 December, the prison was contacted by the man's former partner who told a member of the control room staff that the man had indicated in phone calls and letters that he might harm himself. The control room staff passed this information to officers on the man's wing who immediately spoke to him. Two officers asked him whether he had any intentions of harming himself, which he denied. He also declined the offer to speak to one of the Listeners (prisoners who are trained by the Samaritans to offer confidential support). The man told the officers that he felt his medication was not working properly and the officers made arrangements for him to see a doctor the following day.

5. The man saw another prison doctor on 12 December. During this consultation his medical records were not available. The man's anti-depressant medication was changed and he was referred to see the prison psychologist for a non-urgent assessment. The man was placed onto the waiting list but he died before an appointment was available for him.

6. On 14 December, a Healthcare Nurse (HCN) (who was also a registered mental health nurse) visited the man's wing to conduct an assessment for him. He was not on the wing at the time and the HCN left a note for him to contact her, but he did not. On 21 December, the man returned to see the same doctor he had seen on 12 December. As a result of this consultation his medication was increased. The man's medication was not "in possession" and his treatment chart shows that from 27 December his compliance with taking his medicine was beginning to deteriorate. By 8 January, he was rarely attending to take his medication.

7. The man appears to have found being in prison difficult from as soon as he arrived. Those who knew him described his quiet and occasionally withdrawn nature. It appears that his demeanour deteriorated at some point shortly after the start of January. Although several members of staff who interacted regularly with the man noticed the lowness of his mood, no-one felt concerned

that he might harm himself and the procedures for caring for a prisoner at risk of self harm or suicide (ACCT) were not instigated.

8. The man told staff that he needed to get out of his cell more often. At some point during the days just prior to his death, arrangements were made for him to work in the prison industries rather than attending education lessons as he had been doing up until that time. He was due to start working in the industries the following week.

9. At approximately 7.45am on Friday 20 January, the man went to the treatment hatch on the houseblock to collect his medication. This was dispensed by a HCN. On returning, he chatted briefly to his cell mate, who was just getting ready to leave and go to industries. Neither the HCN nor the man's cell mate noticed anything out of the ordinary about him that morning.

10. A fellow houseblock prisoner was due to see the man for a tutorial session that morning. At about 10.25am, he asked one of the wing officers to open the man's cell. The officer looked through the observation hatch and saw that the man was suspended from a bed sheet that was attached to the hinge of the cupboard high up on the cell wall. He called "code yellow" over his radio (the code used at Blakenhurst to indicate an immediate threat to life) and entered the cell. The officer could not find a pulse in the man's wrist and quickly realised that he would not be able to lift him down on his own and so left the cell to fetch help.

11. Several members of staff were already on their way to help, having heard the "code yellow" call. The officer who had opened the cell door was joined by two other officers and a senior officer (SO). Between them they supported the man's weight and tried to release the sheet from around his neck. One of the prison's HCNs who was responsible for attending to emergencies that day responded to the call along with another HCN. They arrived at the cell within a few minutes and found the officers still attempting to release the man from the sheet. He was released shortly afterwards and the two HCNs commenced Cardiopulmonary Resuscitation (CPR) as soon as the man had been placed on the floor. The HCN responsible for attending emergencies requested a defibrillator and asked for an ambulance to be called. Other members of healthcare staff arrived shortly afterwards and CPR was continued until the paramedics arrived at the cell at 10.44am. The paramedics were unable to obtain any output from the man and one of the prison doctors certified his death at 10.50am.

12. The police were called and officers from West Mercia Constabulary arrived at the man's cell at 11.50am. At about 2.30pm, the Governor asked one of the prison's governors to break the news of the man's death to his family. The governor did this along with one of the prison's chaplains and an officer from West Mercia Constabulary.

13. A search of man's cell following his death revealed a letter that he had written to his former partner outlining his intention to take his life.

14. I make three recommendations. The text also refers to a number of other matters the Governor will wish to consider.

Investigation process

15. Two of my senior investigators visited Blakenhurst and met with the Governor, a member of the Independent Monitoring Board and the Head of Healthcare.

16. Notices were issued to staff and prisoners informing them of the investigation and inviting comment.

17. My investigators were provided with unrestricted access to the man’s prison records, including his medical records. A copy of the post mortem report into the man’s death was kindly provided by HM Coroner.

18. Formal and informal interviews were conducted with prison officers, members of healthcare staff and prisoners.

19. One of my family liaison officers wrote to the man’s parents to explain the purpose of the Ombudsman's investigation and to ask them to contact her with any questions they might have had. My family liaison officer also telephoned the man’s former partner who raised some issues that she wished the investigation team to consider. She wanted to know whether the prison had responded appropriately to her phone call to them on 11 December and whether the emergency response to try to save the man had been adequate. She also wanted to know whether staff at the prison were trained to identify those who may be at risk of suicide or self harm.

20. My family liaison officer wrote to the man’s former partner to confirm that her concerns had been passed onto the investigation team. The man’s parents did not contact my family liaison officer to express any additional concerns.

21. The investigation team liaised with Bromsgrove Primary Care Trust (PCT) who undertook to conduct a clinical review of the man’s medical care whist he was at Blakenhurst. The findings and recommendations of the PCT’s review have informed this report.

22. Both the man’s family and the Prison Service received a copy of my draft report and both have had the opportunity to comment on its content. Their comments are included in the text where relevant

The prisoner

23. The man who is the subject of this report was 39 years old when he was remanded into the custody of HMP Blakenhurst. He had been living with his partner and her children and his son from a previous relationship. He worked as a welder. Although he had previously spent time in custody for minor offences, he had not been in prison since 1987.

24. The man is described by those who knew him as articulate and intelligent. He was determined and focused and had been training to run in a marathon. During his time at Blakenhurst, he formed friendships with several other prisoners who commented that he was finding it hard to come to terms with being in prison and was distressed that his relationship with his partner had broken down.

HMP Blakenhurst

25. HMP Blakenhurst is a category B local prison, meaning that it holds a combination of sentenced prisoners and those on remand. The prison serves the West Midlands area and holds just over 1,000 prisoners. Blakenhurst is divided into five houseblocks which are sub-divided into three spurs. One of these spurs is a unit for vulnerable prisoners and holds approximately 75 prisoners. The prison's inpatient Healthcare Centre has 21 beds and services are commissioned by Redditch and Bromsgrove PCT.

26. Blakenhurst was last inspected by HM Chief Inspector of Prisons in November 2005. The report into this unannounced inspection (published February 2006) concluded that the prison had greatly improved its approach to promoting a safe custodial environment and preventing self harm. It also commented on the improvements to healthcare and mental health services.

27. Seven prisoners took their own lives at Blakenhurst between January 2003 and July 2004. This man's death is the first apparently self inflicted death at the prison since then.

The events leading up to the man's death

28. The man was remanded from Magistrates' Court into the custody of HMP Blakenhurst in November 2005. He was facing two charges of a serious sexual nature.

29. On arrival at Blakenhurst, the man was offered Rule 45 protection (this means that he would be located on a wing especially for prisoners who are vulnerable to attack from other prisoners, usually because of the nature of the offence they are accused of). The man accepted Rule 45 protection and was subsequently located on a houseblock. He spent his first night in Blakenhurst's Segregation Unit and was located on the houseblock the following day. It is unclear why this man was not located onto this houseblock on the day he arrived at Blakenhurst, but it is possible that he was placed into the Segregation Unit while a cell was identified for him.

30. A first reception health screen was carried out that day by a Registered Mental Health Nurse (RMN). The man reported no previous history of mental health or physical health concerns. He had no history of substance misuse, and just a minor skin condition likely to be eczema was identified. The plan of action from a healthcare perspective was that no immediate action was required and he was suitable for normal location work and all cell occupancy. A secondary health screen was also carried out for the man on 17 November. Again, no issues of concern were recorded.

31. Also on 17 November, a cell sharing risk assessment was carried out. This concluded that the man presented a low risk of harm to others and he was subsequently located in a shared cell.

32. On 25 November, the man was assessed by a member of healthcare staff (whose identity could not be established by the investigation team) and was found to be fit to attend court. The man had contact with medical staff again on 5 December when he saw one of the prison doctors. During the consultation, he discussed feeling depressed and low and said that he was experiencing headaches. He was prescribed a routine anti-depressant, Fluoxetine, 20mg for 14 days.

33. On 6 December, the man was visited by his solicitor. She told the investigation team that, as the committal papers had not been received by that stage, there had been a limited amount of preparation for the case. The solicitor explained that she had felt the same concerns for the man as she would for anyone facing such serious charges. However, she had specifically asked him how he was coping and he had replied that he was managing to hold things together for the sake of his son. The solicitor said that a bail application had been scheduled for 16 January in the event that the man's committal papers had still not arrived. However, the papers did arrive some time before that and a

letter was sent to Wolverhampton Crown Court on 13 January to withdraw the bail application.

34. On 10 December, one of the regular houseblock officers made an entry in the man's wing records. The entry indicated that he was a quiet and timid prisoner who might be vulnerable to bullying or conditioning by other prisoners and he needed to be monitored. On the following day, 11 December, the officer made a further entry. It read as follows:

> "Ref phone call from Comms that [the man] has threatened to kill himself via letters and phone calls to his wife and children."

35. The officer who made the entry told the investigation team that, following the call from the communications room, he and another wing officer went to speak to the man immediately. They spent some time in the wing office with him and asked him how he was feeling and if he was experiencing any difficulties or was feeling low. The officers asked the man if he would like to speak to a Listener or someone from the chaplaincy but he declined. The officer went on to explain that he and the other officer specifically asked the man whether he was thinking about self harm, explaining that his partner had contacted the prison to raise her concerns. The man maintained that he was not considering harming himself but that he did think that the anti-depressant medication he was taking was not working properly.

36. One of the officers made a telephone call to the healthcare centre while the man was still in the office and asked for an appointment to be arranged for that afternoon. He was told that it would not be possible but that he could be seen the following day. The officer recalled that the confirmation slip for the appointment time arrived later that afternoon and he personally took it to the man.

37. Both of the officers who spoke with the man that day explained that they had been trained in how to use the Prison Service's procedures for caring for those at risk of suicide or self harm. The Assessment, Care in Custody and Teamwork (ACCT) process requires that, if a member of staff believes a prisoner to be at risk of suicide or self harm, then ACCT procedures are instigated. Both officers felt confident that they would have instigated these procedures for the man if they had thought it necessary. He had not given them any reason for concern during their conversation with him.

38. Following this conversation with the man, one of the officers made the following entry into his wing record:

> "Spoke with [the man] with reference to the telephone call from his wife. [The man] states he has no intention of self harm or killing himself. He also stated that he is receiving medication for, as he puts it, split personality, which is not working. We

have arranged with Healthcare to take a look at his medication and for him to be assessed."

39. On the following day, 12 December, the man was seen by another prison doctor. A note was made in his medical records that he was experiencing headaches and panic attacks and that the medication he had been given the week before did not appear to be working. He explained that he had been prescribed Venlaxafine a week previously. The man's medical records were not available during this consultation and he was mistaken about his earlier prescription: he had in fact been prescribed Fluoxetine. The clinical reviewer comments that this medication would not have started to take effect until 7-14 days after he began to take it.

40. The doctor made some notes about the man's history, including that the headaches had started approximately three years earlier and that he had previously been involved in a road traffic incident. The doctor changed his medication to Stelazine, 2mg for 10 days, and also 10mg of Propanolol. The doctor also made a note to refer him to the prison's psychologist. There is no reference made to the man having feelings of depression or having thoughts about self harm or suicide. The doctor completed the referral for the psychologist the following day, indicating that the man's need for assessment was not urgent and documenting the reasons why he had been referred. These included his anxiety, headaches and panic attacks. Again, no reference was made to self harm or suicidal thoughts.

41. The prison's psychologist told the investigation team that she had never assessed the man. She explained that she received referrals to see individuals either verbally in the Multi Disciplinary Mental Health meeting on Friday lunchtimes or via a standard referral form. As the psychologist does not work full time at the prison, these would be left in her in tray. For referrals which have not been identified as urgent (as was the case for this man) the individual would be placed on a waiting list. The psychologist told the investigation team that it would not be unusual for a non-urgent patient to wait for 6-8 weeks before they are seen.

42. On 14 December, a Healthcare Nurse (HCN) made an entry in the man's medical records indicating that she had been to the houseblock and attempted to see him. The HCN is a Registered Mental Health Nurse and had intended to carry out an assessment. When she got to the houseblock, the man was at education and so she did not speak to him and instead spoke to officers on the wing (who have not been identified). She asked the officers if they had any further concerns regarding the man's mental health and was told that they did not. The HCN advised the officers to ask for a referral for the man to see someone if any further problems arose. In interview, the HCN told the investigation team that she left a note for the man in his cell, asking him to get in touch if he wanted to speak to someone from the Mental Health In-reach Team. She explained that she then made a note in her own

diary to review the man's medical records at a later date. The HCN explained that, when she checked the man's medical records some time later, she observed that he had been seen by a doctor and so was satisfied that he was engaging with medical staff and any further issues would be picked up. She could not remember exactly when she had done this.

43. It has not been possible to establish who contacted the HCN as no written referral was made requesting that the man be seen by the Mental Health In-reach Team. The clinical reviewer's investigations indicate that Healthcare frequently takes such referrals verbally from wing staff and that these are not always recorded, logged or prioritised. It seems highly likely that the houseblock staff contacted Healthcare by telephone, although no members of staff the investigation spoke to remembered doing this.

44. The man failed to attend a medical appointment on 16 December. It appears from the clinical reviewer's investigations that this appointment had been arranged as a follow up to the man's appointment with the first prison doctor on 5 December, and was not related to his appointment with the second doctor on 12 December.

45. On 21 December, the man saw the second prison doctor again. The doctor increased the man's prescription of Stelazine from 2mg twice a day to 5mg. The Stelazine was a 'not in possession' prescription. Initially the man attended on the majority of days for his twice daily dose. However, from 27 December 2005 his compliance with taking medication deteriorated, resulting in him taking his medication only once a day.

46. Further notes were made in the man's wing record around this time. On 17 December, a wing officer wrote "No problems, keeps himself to himself." On 24 December, one of the officers who had spoken at length with the man on 11 December noted that he was "Quiet and very much a loner. Staff are to be vigilant around him." The officer explained that this comment had been intended to alert other officers that they should be aware of how quiet and insular the man was, and to try and encourage him to talk.

47. A week later, on 31 December, another wing officer made an entry into the man's wing record. He observed him to be a very quiet and respectful prisoner who was very polite to staff and who spent a lot of time in his cell. He noted that he seemed "settled". Similarly, on 7 January an officer noted that the man was very quiet and shy but had settled well and that there were no concerns that week.

48. Around this time, one of the prison's chaplains had frequent contact with the man. The chaplain explained to the investigation team that the man came to evening communion fairly regularly and that she could specifically remember him coming to communion on the two Tuesdays

prior to his death (Tuesday 10 and 17 January). On Tuesday 10 January, the communion was attended by only two prisoners; the man who is subject of this report and another prisoner from the Houseblock. On that evening, the chaplain asked if the two men would like to write down any thoughts they might have and offer them as a prayer to God. The man asked that his prayer only be read out if something were to happen to him. The chaplain, the man and the other prisoner had an open discussion about what he had meant by that comment and whether he was intending to harm himself. He said that he had only been talking metaphorically. The other prisoner who had attended the communion that evening told the investigation team that he had taken the man's comment to be an indication of his low mood and had not felt that he was intending to harm himself.

49. The clinical reviewer notes that by 8 January the man was rarely attending for his medication. On 11 January, he was seen by a doctor and complained of anxiety attacks. He said that he had not had any suicidal thoughts and it was agreed that he would return a week later.

50. The prisoner who attended communion with the man who died told the investigation team that he spoke to him very regularly. The two men would play cards and both often attending evening congregation. This prisoner had been encouraging the man to get involved in a scheme in which prisoners help other prisoners to improve their basic skills in English and maths, known as "Toe by Toe" (I am myself a strong supporter of Toe by Toe). The prisoner told the investigation team that some time during the week or so before his death, the man who died had asked one of the officers if he could speak to a Listener. (These are prisoners who are trained by Samaritans to offer a confidential support service to other prisoners in crisis.) The prisoner explained that the man had not been provided with a Listener and had been met with an unsympathetic response from the officer. The prisoner provided the name of the officer who he believed had turned down the man's request. The investigation team interviewed this officer who explained that he had no recollection of ever having spoken to the man and certainly not of him asking to speak to a Listener. The staffing detail for the week preceding the man's death indicates that the officer was not working on the houseblock during that period.

51. During this time, the only Listener on the houseblock had been suspended from his duties and there was therefore not a resident Listener on the wing.

52. An entry in the man's wing record on 14 January seems to indicate a change in the way he was presenting on the wing. One of the wing senior officers (SO) noted the following:

> "Needs more things to do during the day as it has been noted that his mood is starting to deteriorate. He is a bright prisoner who needs to be using his brain more."

53. On 16 January, the man appeared in court. His solicitor explained to the investigation team that the purpose of this appearance had been to apply for bail. However, as has already been highlighted, as the man's committal papers had been received by this date, his application for bail had already been withdrawn and his appearance at court would have been unnecessary. The man's cell mate commented that he had found this experience stressful and had felt frustrated by it.

54. During the early part of the week beginning Monday 16 January, the man received some news in his education class which seemed to upset him. One of the teachers at Blakenhurst, told the investigation team that he had been told that the Thursday afternoon teaching sessions were going to be abandoned due to financial difficulties. The teacher explained that while most of the prisoners affected were disappointed and complained, the man who is the subject of this report went very quiet and seemed genuinely upset at the prospect of one of the classes being cancelled. He explained to the teacher that he wanted to be out of his cell as much as possible and seemed anxious that he needed to be busy all the time. Because of this, he had taken the decision to go back to working in industries rather than attending education. It appears that the man had originally swapped from industries to education as he did not like being in the noisy, crowded environment. However, he felt that at least going back to working in industries would get him out of the cell more. He also felt that the manual hard work in being in industries would help alleviate his insomnia.

55. The man attended evening communion again on Tuesday 17 January. The chaplain told the investigation team that she had been concerned for him on that night and he had appeared very quiet and withdrawn. Worried by this apparent decline in his mood, she went to the houseblock and discussed her concerns with officers there. She explained that it was not her impression that the man was suicidal but rather that he was struggling to cope with the pressure of his impending court case. The chaplain could not remember which officers she spoke to. In addition to speaking to staff on the man's Houseblock, she left a note for a volunteer who worked at the prison to go and see the man and see how he was. The volunteer did so and reported back to the chaplain that the man had seemed okay and had been talking about his plans for the future.

56. The teacher told the investigation team that he had talked about the man who died to the officers on the houseblock several times. His afternoon teaching sessions with the prisoners on that houseblock took place in the teaching room located on the landing so he regularly saw the landing staff. He explained that he had spoken to staff on occasions to try and organise for the man to spend more time out his cell in the mornings. It was the teacher's impression that these conversations had never achieved much and that the man continued to find it difficult to cope with the amount of time he spent in his cell in the mornings.

57. Following his conversation with the man regarding the cancellation of one of the afternoon teaching sessions, the teacher recalled speaking to the houseblock officers (he could not recall which officers by name) about man's reaction and of his concern for him. He discussed the possibility of instigating ACCT procedures for the man and asked for their advice. The officers said that they did not personally feel that they had reason to be concerned that the man would harm himself but encouraged the teacher to open ACCT procedures if he had concerns. Having discussed the issue, the teacher did not feel there was cause to be specifically concerned about the man harming himself and he took no further action.

58. The SO who made the entry in the man's records on 14 January told the investigation team that he believed he could recall talking to the man on the morning of Wednesday 18 December. He explained that he was mindful of the previous entry he had made in the man's wing record and had gone to check on how he was doing. The man had asked about the possibility of a job on the wing in order to get out of cell more. The SO explained that there were no jobs available at that time but that he would be kept in mind if anything came up. He talked to the man about his disappointment with the cuts to education classes and considered that he seemed to be quite down. The SO told the investigation team that he specifically asked the man whether he was thinking about harming himself and he stated that he had absolutely no intention of doing so. The SO did not make a note of this conversation in the man's wing record.

59. Also on 18 January, the man was seen by the triage nurse and was referred to see the doctor about his panic attacks and insomnia. He was seen by a prison doctor who he had not seen before. He described experiencing generalised anxiety attacks but stated that he had not experienced any psychotic episodes or suicidal thoughts. The doctor recorded the man's poor compliance in relation to anti-depressant medication, altered his prescription to Escitolopram 10mg and encouraged him to take his anti-depressants. The doctor at this stage was under the impression that the man was being seen by both the psychology service and a RMN, neither of which was true.

60. The man's cell mate described him as quite a 'down' person who did not talk about his problems. He described how the man found it hard to be locked up in the cell, especially when he was on his own. He explained, however, that even though the man hated being locked in the cell he would sometimes stay in there even when the door was unlocked and he was free to go onto the wing.

61. Another prisoner who spoke regularly to the man described him as an unhappy person. He explained that the man had talked to him about the charges he was facing and had expressed his upset at the effect it was having on his former partner and son. This prisoner told the

investigation team that the man had once said that if he had had a gun he would take his own life. He had believed him to be telling the truth and considered that he was depressed. The prisoner had not relayed this conversation to anyone or approached a member of staff to express his concerns for the man.

62. The man's relationship with his partner had broken down since his imprisonment. In addition to distress at the breakdown of his relationship, it appears that he was finding the separation from his son very hard to cope with and was distressed about how his son was being affected by the charges he faced.

63. On 19 January, the man's solicitor wrote to advise that he was to cease all contact with his former partner as she was a potential prosecution witness. It has not been possible to establish whether the man received this letter before his death. Given the time it would take for the letter to have been processed by the prison, it seems unlikely that he would have.

Friday 20 January

64. The man's cell mate told the investigation team that the man had appeared to be his normal self on the morning of his death. The man was the first out of bed and to make a cup of tea, which was usual. At approximately 7.45am, he went down to the treatment hatch on the ground floor landing of the houseblock to collect his medication. The medication was given to him by a Healthcare Nurse. The HCN who was giving out medication that morning told the investigation team that he asked each of the prisoners collecting medication a few questions, such as "Did you have an okay night?" and "How are you feeling this morning?" He does not recall anyone having specific problems that morning and noticed nothing of concern when he spoke briefly to the man.

65. The man arrived back at his cell some time just before 8.00am. The man's cell mate was just about to leave to go to work in industries and had a brief conversation before he left. The man said he was looking forward to Monday as he said he would be working in industries from then and so would be out of the cell in the morning. He said that he would clean the cell that morning as it was his turn. The man's cell mate then said goodbye and left the cell. The investigation team discovered that there was some confusion over whether the man was actually due to start work in industries on that morning. The teacher believed that that he should have been and one of the wing officers confirmed that he was on the list to start on that day. However, the man told the wing officer with the list that he wanted to start from the following Monday, an intention he then reiterated to his cell mate as he left the cell that morning.

66. The prisoner who attended communion with the man was due to see him during the morning to discuss the man's plans to become a Toe by Toe tutor. He told the investigation team that, at about 8.45am, he saw the man going into his cell and called to him that he would see him later that morning. He does not recall whether the man answered but he gave him a "thumbs up" and went into his cell. The wing officer who had the list for those attending industries recalled that it was about 09.10am when he locked the man back in his cell.

67. The prisoner who was due to see the man about Toe by Toe had another prisoner to see that morning. He asked the wing officer if he would unlock this other prisoner so that they could have their tutorial. The officer told the investigation team that he believed this would have been at approximately 10.00am. After this first session was finished, at approximately 10.25am, the prisoner asked to see his second Toe by Toe prisoner; and he and the officer made their way to the man's cell.

68. The officer explained that he and the prisoner made their way to cell B2-13, the man's cell. Before opening the door, the officer opened the observation flap and saw the man hanging from the locker at the back of

the cell, suspended by a sheet that was wrapped around his neck. The officer called “code yellow” on his radio. (In Blakenhurst, code yellow is a term used to alert other staff that there is an immediate threat to life and that urgent assistance is required.) The officer entered the cell and saw that the man had wrapped what appeared to be an entire bed sheet around his neck and had managed to secure it in the locker by wedging it inside the hinges of one the doors. He felt for the man’s pulse in his wrist but could find none. The officer told the investigation team that, due to the man’s colour and appearance, he feared he was already dead. However, his priority was still to remove the ligature from around his neck and to begin emergency first aid.

69. The locker from which the man had suspended himself was very high and the officer explained that he could see immediately that he would not be able to release the man from the ligature without assistance. He appeared to have stood on a chair to reach the top of the locker and have then stepped off it or kicked it away. One of his feet was still partly resting on the chair. The officer estimated that he was in the cell for about 20 seconds before he took the decision to leave the cell and go to the nearby office to summon help. He left the cell, locking it behind him, and began to make his way to the office some 20 yards away. He did not get as far as the office before other members of staff were already making their way towards him. He called to them that he needed their help and turned back towards the man’s cell. The officer went back into the cell, along with two officers and a senior officer (SO). The officer who had found the man and the SO supported his weight while one of the other officers attempted to untie the ligature. The thickness of the sheet made it impossible to cut through it with an anti-ligature knife (known as a ‘fish knife’) although the SO and one of the officers both attempted this. One of officers went back to the office and called for another SO who was in the Detail Office to ask for his assistance. The SO made his way to the houseblock, arriving as the other officers were still attempting to cut the man down.

70. Two Healthcare Nurses were working together in the Healthcare Centre when they heard a ‘code yellow’ call over the radio. One of the HCNs was the nurse responsible for attending any emergencies that day, and the other was the HCN acting as the member of medical staff to support her. The HCN who was responsible for immediate response noted in her police statement that she received the code yellow call at approximately 10.25am. She responded to the radio message and confirmed that she was on route to the houseblock. The other HCN went with her, taking the emergency bag with him. It took the two HCNs about two minutes to reach the houseblock. On arriving at the man’s cell, the two nurses saw that three officers were attempting to release him from the ligature. One of the HCNs helped the officers and they managed to untie the knot and unravel the sheet from around the man’s neck. He was placed onto his back, with his head towards the door of the cell. The emergency response HCN asked for a defibrillator machine to be brought to the cell and then took out a pocket mask and

began to carry out Cardiopulmonary Resuscitation (CPR). She also requested that an ambulance be called.

71. One of the prison's Principal Officers (POs) was designated as Oscar One that day, meaning that he was responsible for the operational running of the prison and of managing any incidents that occurred. As part of the protocol following a member of staff making a 'code yellow' request, the officer acting as Oscar One is notified of the location of the incident by the Control Room. As the PO was making his way around the house blocks that morning, he was alerted that a 'code yellow' had been called from an officer in the houseblock and so he immediately made his way there. He estimated that it took him no more than a minute to arrive at the houseblock. The PO arrived at the man's cell at the same time as another officer. He instructed the officer to start a log, which he duly did. The PO responded to the HCN's request for an ambulance and contacted the Control Room over his radio. He gave brief details of what had happened and requested that a call be made for an emergency ambulance. The Control Room log indicates that a call for an ambulance was made at 10.32am.

72. The emergency response HCN administered mouth to mouth whilst the other HCN started chest compressions. Another HCN, who was in the Healthcare Centre, estimated that she heard the radio call requesting the defibrillator just before 10.30am. She and a Healthcare Assistant (HCA) made their way to the houseblock and arrived within a few minutes. On arrival she prepared the defibrillator and instructed the HCNs to stop CPR while she attached this to the man. She was not able to attain any output and so the CPR continued. A further HCN had heard the 'code yellow' message on her radio and so made her way to the houseblock. On arriving, she found that the man was already being attended to by other healthcare staff and so assisted by passing equipment.

73. The PO acting as Oscar One told the investigation team that, within approximately 20 seconds of arriving at the man' cell, he requested that the duty governor also attend. The Control Room log indicates that a call was put out requesting that the duty governor attend the houseblock at 10.37am.

74. The prison's nurse sister was in the Healthcare Centre and was told by another member of healthcare staff that her help was needed. The officer completing the log noted that that the sister arrived at the man's cell at 10.38am. The sister took over CPR and asked for all of the non-emergency staff to leave the cell. Because of size of the cell and where the man was positioned on the floor, the officers who had arrived at the cell first remained at the back of the cell whilst the medical staff attended to him.

75. The paramedics arrived at the prison at 10.40am and at the man's cell at 10.44am. CPR had been carried out continually until they arrived and

took over, some twenty minutes after he had been found. They were unable to obtain any output. One of the prison's locum doctors was asked by the Healthcare Manager if he could certify the man's death. He did so at 10.50am.

76. The PO told the investigation team that, when he arrived on the houseblock , staff were locking prisoners behind their doors. He instructed staff to continue with this. The prisoner who had been waiting to see the man for his Toe by Toe session (and had been outside the man's cell when he was discovered) had realised quickly that something very serious had happened to the man. He told the investigation team that the officer had told everyone to get behind a cell door immediately and that prisoners had done so. He explained that members of the chaplaincy came to see him and talked to him until his cell mate came back from industries a little later in the morning.

77. The man's cell mate described how he had come back from industries late that morning and that he was not sure why there had been a delay. When he tried to make his way to his cell, he was stopped by an officer and taken to the shower block where the officer explained what had happened. He said that he was regularly checked on by staff and also had the chaplain to talk to.

78. The paramedics left the prison at 11.05am. It appears from the Action Checklist completed by the duty governor that West Mercia Constabulary had been contacted at 10.45am and arrived at the man's cell at 11.50am.

79. The duty governor led a 'hot debrief' at 11.30am in the prison chapel. The debrief was widely attended by both discipline and healthcare staff who had been involved in trying to save the man that morning. The debrief was minute and staff were reminded of the availability of members of the Care Team to offer them support, and of the need to be mindful of the effect the man's death might have on prisoners.

80. The governing Governor asked one of the other governors to break the news of the man's death to his family. This governor estimated that he was asked to do this at approximately 2.30pm. The man's records had already been consulted and had shown his next of kin to be his parents. The governor had not been trained in family liaison and had never previously broken the news of a death. He consulted Prison Service Order 2710, which provides guidance. The prison has its own Family Liaison Officer's guidelines which contain an information gathering checklist. This was completed by one of the prison's chaplains and included information about the man and his family circumstances as well as the known details about his death. In addition, a risk assessment was completed, including any known information about the family or neighbourhood that prison staff needed to be aware of. Nothing of this nature was recorded. It had been decided that the governor and the chaplain (whose communion the man had attended) would go to visit the

man's family together and that they would be accompanied by a police officer from West Mercia Police. They waited approximately half an hour for an officer to arrive and take them to the man's parents' address, arriving there at 4.00pm.

81. The governor explained that, on arriving at the man's parents' home, he broke the news of his death. The governor was aware that the man had a son and his parents explained that he now lived with the man's former partner. The man's parents asked that the governor and the chaplain break the news to the man's son. Agreeing to do this, they were aware that the man's son was young and that they did not want to tell him of his father's death without him being accompanied by an adult. With the assistance of the police officer, they were able to locate the man's former partner and asked for her to return home as they had needed to break some news to her and the man's son. After they had done so, the governor, chaplain and the police officer left the house, explaining that one of the prison's senior officers would be acting as their family liaison officer (FLO) and that he would be visiting them soon.

82. The senior officer appointed as the prison's family liaison officer contacted the man's parents and former partner and has maintained regular contact with the family. The man's family asked the prison chaplain to carry out the service at his funeral, which she did. The prison covered the costs of man's funeral.

83. A subsequent search of the man's cell revealed that he had written a letter to his former partner, outlining his intention to take his life. It is not clear when this letter was written.

Discussion of the issues

84. I note that this man spent his first night in the prison in the Segregation Unit. In all likelihood, this was because he was on Rule 45 protection and was awaiting a place on the houseblock. I share the view, expressed by HM Chief Inspector of Prisons in her report of February 2006, that it is not appropriate for prisoners who have been afforded Rule 45 protection to be located in the Segregation Unit for this reason.

The appropriateness of the man's assessment by Healthcare staff

85. The initial assessment of the man's health was carried out appropriately. In the two months between his arrival at Blakenhurst and his death, he was seen by several different members of healthcare and his medication for depression was altered three times in the space of six weeks. The clinical reviewer recommends a consensus about the treatment of depression to be established, in consultation with prison pharmacists and prison GPs. The reviewer suggests that this should include a review of appropriate evidence based medication and the length of time needed for the chosen drug to be effective.

86. The clinical reviewer also concludes that there is a need for improved sharing of relevant information between wing staff and medical staff. I note that, when the Registered Mental Nurse was requested to see the man on 14 December, she was unaware that information had been received suggesting that he could have been intending to harm himself. The clinical reviewer also recommends a review of the referral process to the mental health team with the aim of establishing a robust system with clear referral criteria. This would involve the creation of an audit trail allowing healthcare professionals to track the progress of patients and preventing patients being lost in the system. In addition, the reviewer recommends that a policy should be established which would remove the onus on the patient to re-engage with the Mental Health In-reach Team when they may be experiencing episodes of mental distress[1].

87. I fully endorse the reviewer's recommendation that there is a need for a more robust system for recording, prioritising and monitoring prisoners who are brought to the attention of the Mental Health In-reach Team. However, I also consider that healthcare staff should be reminded of their right to review the contents of a prisoner's wing file if they believe this would be relevant to their duty to care for the prisoner as a patient. In the Registered Mental Health Nurse's case, she could have quite reasonably requested to see the man's wing file in order to gain an understanding of why he had been referred for an assessment.

[1] I note that, in their response to the draft version of this report, the Prison Service said they believed the clinical reviewer's report confused the two groups of staff responsible for dealing with prisoners with mental health problems. The Prison Service advised that those with severe and enduring mental health problems fall into the remit of the In-reach staff. Those with less acute mental health needs are cared for by the in-house Registered Mental Health Nurses (RMNs).

88. The clinical reviewer notes that, although the majority of entries in the man's medical records were legible, this was not the case for all entries and some were not signed or dated.

89. The clinical reviewer also makes the following recommendations:

- A common formulary for prescribing anti-depressants should be maintained, and monitored by prison medical staff at defined intervals.

- If a referral from the wing is received and contact cannot be made, this should be recorded in the Inmate Medical Record (IMR) and also within the prisoner's wing records.

- If staff have been concerned that a prisoner may be at risk of self harm but subsequently make a decision not to instigate ACCT procedures for a prisoner, it should be clear from the prisoner's records why that decision has been made.

- A formal process for monitoring referrals to the forensic psychologist should be in place and prisoners on the 'waiting list' should be reviewed on a regular basis by the multi disciplinary team to identify if their needs have changed.

- Care should be taken when a prisoner's medical records are not available, especially if significant alterations to medications are being made.

- The standard of record keeping in prisoners' medical records should be regularly audited against relevant guidelines.

90. The clinical reviewer indicates that more consideration should perhaps have been given to instigating ACCT procedures for the man, as he was demonstrating depression, anxiety and had reportedly made suicide threats. I consider that any one of the members of staff who was aware of his low mood would have been justified in opening an ACCT for him. However, there was a lack of information sharing between healthcare staff, Mental Health In-reach staff and discipline staff. This appears to have resulted in no one person being aware of all the significant factors affecting the man's state of mind and therefore his risk of harming himself. While in hindsight it would seem that ACCT procedures should have been initiated, the man's presenting symptoms were not such that the decision not to have done so can be criticised.

The care of man by other prison staff

91. The houseblock accommodates some 70-80 prisoners. For much of the time during the day, the wing is staffed by two officers. There are officers available if they are needed on an adjacent houseblock and there is also a senior officer responsible for supervising both

houseblocks. The houseblock where the man died does not operate a personal officer scheme and staff explained to the investigation team that prisoners are happy to approach any member of staff. The quality and frequency of entries in the man's wing record tends to suggest that, despite there being few members of staff on the wing, the officers made efforts to interact with him and to document many of the specific conversations of note.

92. Many other members of staff, including those from Chaplaincy, Healthcare and Education, also interacted with this man and may have had cause to make entries in his wing records. It should be considered good practice to encourage staff from all disciplines to share information in this way. It can only assist in informing staff about individual prisoners and help raise awareness about those who might be at risk of self harm.

93. Both the chaplain and teacher who saw the man regularly spoke to officers on the houseblock about their concerns for this man, although neither specifically had concerns about him harming himself. Discussing worries about individual prisoners with other members of staff is to be encouraged. The chaplain and the teacher both felt confident that they would have instigated ACCT procedures if they had felt it appropriate. However, neither considered that the man had intentions of harming himself, rather that he was struggling to cope with his upcoming court case and the pressures of being in prison.

94. The man's former partner asked the investigation team to consider whether staff are appropriately trained to identify those who may be at risk of suicide or self harm. During their training on how to use the ACCT system, staff are trained to look for both the physical and behavioural changes that may indicate that a person is vulnerable to harming themselves. Staff are also trained to respond to prisoners who may be experiencing distress by talking openly with them, as well as by observing changes in behaviour and attitude.

95. The man's former partner was also concerned about whether the information she passed onto the prison on 11 December was dealt with appropriately. The investigation team found that, once the information was received by a member of staff in the prison's Control Room, the information was swiftly communicated to staff on the houseblock. The wing officers, on receiving the information from the Control Room, took entirely appropriate action. They spoke at length with the man and, in obtaining a doctor's appointment for him, attempted to help him address difficulties he was having with his medication. Both officers felt satisfied that the man did not intend to harm himself, but that they would have felt confident to instigate ACCT procedures if they had felt it necessary.

Attempts to help the man spend more time out of cell

96. As is the case for many prisoners, the boredom and stress of being locked in a cell was something this man found hard to cope with. He

had decided that he would stop attending education as it did not afford him enough time out of his cell and was due to start in industries on the Monday following his death. In addition, arrangements had been made for him to become a tutor on the Toe by Toe programme which would mean more time out of his cell.

97. The investigation team were told by some of the prisoners that it was extremely rare for the houseblock prisoners to be given exercise outside. They were told that exercise was given at least several times a week but that it sometimes coincided with the hour in the afternoon when prisoners wanted to take showers and collect their meal. It was explained that pressure on staff numbers meant that this was sometimes unavoidable. Manifestly, prisoners should be given the opportunity to go outside for exercise without having to forsake their meal or shower. Nevertheless, there seem to have been efforts made to find opportunities for the man who is the subject of this report to spend more time out of his cell through involving him in other activities.

98. Other prisoners who were friends with the man commented on his quietness and occasional unwillingness to come out of his cell even when he was able to do so.

The man's access to support

99. A fellow prisoner who played cards with the man told the investigation team that he had asked an officer to speak to a Listener a week or so before his death. The prisoner named the officer who be believed had refused to get a Listener for him. I have found no evidence to suggest that this was the case. Indeed, the officer in question was not working on the houseblock at the relevant times.

100. It was brought to the attention of the investigation team that there had been no resident Listener on the houseblock for some weeks. One of the houseblock prisoners explained that, while in theory Listeners from anywhere in the prison should be able to support a prisoner on the houseblock, in practice there was a reluctance to engage with prisoners on that wing because of the nature of their alleged offences. Whilst it has not been possible to establish whether the number of Listener referrals reduced on the houseblock after their Listener was suspended, it is clearly of benefit to the residents to have access to a Listener who also lives on the wing.

101. The man who died appeared to be finding it very hard to cope with the breakdown of his relationship, a situation which is sadly not unusual in prison. He spoke of his distress to individual prisoners, and members of prison staff including the chaplain were aware that he was finding the stresses of prison hard to cope with. When the prison was contacted by the man's former partner on 11 December about concerns about his intentions to harm himself, the staff involved acted swiftly and with sensitivity.

Response of staff on 20 January

102. On the morning of the man's death, staff responded swiftly and appropriately to try to save him. Each member of staff the investigation team spoke to about the use of 'code yellow' understood what it meant and how to respond. All the members of staff who tried to save the man had been trained in suicide awareness and understood the importance of releasing the ligature from around his neck. The two officers who were first to arrive and help the man had received heart start training in the past two years, and all officers are equipped with anti-ligature knives.

103. The first two Healthcare Nurses arrived at the man's cell within minutes of hearing the 'code yellow' call. They took the emergency bag with them and asked for a defibrillator machine as soon as they arrived and realised it would be needed. An ambulance was also requested. Further healthcare staff arrived very quickly and the senior nurse took over resuscitating the man until the ambulance staff arrived some 12 minutes after they had been called.

104. The Principal Officer who was Oscar One that day estimated that he arrived at the man's cell within a minute or so of hearing the 'code yellow' call. He ensured that a log was kept. He also kept the duty governor informed of what was happening.

105. Following the man being pronounced dead at 10.50am, the duty governor held a hot debrief for staff. The debrief appropriately drew attention to the possible needs of staff who had been involved in trying to save the man, but also highlighted the need to be sensitive to prisoners' reactions to his death.

106. The investigation team interviewed the majority of the staff who were involved in trying to save the man on the morning of 20 January. All of those they spoke to spoke favourably of the help and support they had received following this tragic death. However, the man's teacher, a member of staff who knew the man well but who was not involved in trying to save him that morning, felt that it was unfortunate that he was not offered support as he would have welcomed it.

Suicide prevention at HMP Blakenhurst

107. The recent report following an unannounced inspection by HM Chief Inspector of Prisons noted that safer custody is a priority for Blakenhurst, and that a range of initiatives have resulted in a significant reduction in incidents of self harm. The investigation team found that the staff they spoke to demonstrated a good level of awareness of the ACCT procedures and were confident about instigating them if necessary.

108. The investigation team were told about Blakenhurst's Insiders scheme by one of the prisoners who co-ordinated the work. The scheme aims to

provide a support and information service both to newly arrived prisoners and to those who may need specific help. The Listener and Insider schemes were talked of favourably by prisoners, but there was a clear concern about the absence of a Listener on the houseblock.

Family Liaison

109. Once the governor who was asked to break the news of the man's death to his family was aware that he would be making this visit, he took appropriate steps to ensure that this was done as quickly as possible. He did this without jeopardising his or his colleague's safety. The prison has developed its own local guidance for staff when delivering the news of a prisoner's death, and has also produced a useful information pack to be given to bereaved families. The governor and the chaplain worked closely with the police to ensure that they did not deliver such sad news to the man's son inappropriately, and their sensitivity in this matter is commendable. The governor was not aware that he was going to break the news of the man's death to his family until almost four hours after he died. Whilst no criticism is made of the governor's actions in preparing to break the news to the man's parents, it is noted that it would have been desirable for them to have been visited before 4.00pm, some five and a half hours after his death.

110. I have found the prison's family liaison officer's efforts in liaising with the man's family to have been sensitive and timely.

Could this man's death have been prevented?

111. It is not possible to know whether a specific event triggered the man's decision to take his own life or for how long he had considered it. It is evident that he frequently spent time alone in his cell and that the morning of 20 January would not have been his first opportunity to attempt to take his life. It is not clear whether the man had received the letter sent by his solicitor on 19 January indicating that he could not contact his former partner, but this seems very unlikely.

112. It appears that many of those staff and prisoners who regularly came into contact with the man were aware of his distress. However, given the severity of the charges against him and the deterioration of his personal circumstances, his state of mind appeared to others to be understandable. Other than his comment about a gun to a fellow houseblock prisoner, he never appeared to give any indication that his distress would lead him to harm himself.

Findings and recommendations

113. It is not appropriate for prisoners on Rule 45 protection to be located in the Segregation Unit on their first night in custody and I suggest that steps are taken to prevent this happening.

114. The man was clearly finding his time in prison difficult to cope with. He was facing very serious charges and his relationship had broken down as a result. He did appear to talk to some prisoners and staff about his difficulty in coping. But, with the exception of one prisoner who by his own admission did not tell staff about his concerns, none of those whom he confided in considered that he was in danger of harming himself. Rather, it was believed that his expressions of despair were simply indications of how low he was feeling at the deterioration of his personal life and the prospect of his upcoming court case.

115. The man had frequent contact with healthcare staff at the prison and had been prescribed anti-depressants. Taking into account the findings of the clinical reviewer, I consider that there were missed opportunities to engage with him in a way which might have helped him to address his depression and anxiety. Although he came to the attention of the Mental Health In-reach Team and had been referred for an appointment with the prison psychologist, inadequate referral and monitoring systems resulting in his 'slipping through the net'.

116. **I recommend that consideration is given to the following findings, as outlined in the clinical review:**

- A consensus about the treatment of depression should be established in consultation with prison pharmacists and prison GPs. This should include a review of appropriate evidence based medication and the length of time needed for the chosen drug to be effective.

  The Prison Service accepted this recommendation locally. They responded that: "The appointment of a clinical lead will enable a protocol to be drawn up regarding the prescribing of anti-depressants. This will be forwarded to the drug and therapeutic committee for agreement."

- There should be a review of the referral process to the mental health team with the aim of establishing a robust system with clear referral criteria. This should incorporate the creation of an audit trail to allow healthcare professionals to track the progress of patients and safeguard against patients being lost in the system. A policy should be established which would remove the onus on the patient to re-engage with the Mental Health In-reach Team when they may be experiencing episodes of mental distress.

The Prison Service accepted this and advised that: "A new system had been established to monitor referrals and ensure an appropriate professional sees the patient. A system to be developed to give the patient the necessary information to enable them to re-engage with the mental health team following discharge from that period of care. Those with severe and enduring mental illness will remain on the patient list until discharged from the establishment."

- A common formulary for prescribing anti-depressants should be maintained, and monitored by prison medical staff at defined intervals.

  The Prison Service accepted this recommendation and commented: "A formulary is being developed which will encompass anti-depressants and all other medications."

- If a referral from the wing is received and contact cannot be made then this should be recorded in the IMR and also within the prisoner's wing records.

  This was also accepted by the Prison Service: "Notice to be issued to all staff regarding appropriate documentation."

- If staff have been concerned that a prisoner may be at risk of self harm but subsequently make a decision not to instigate ACCT procedures, it should have been clear from the prisoner's records why that decision has been made.

  In accepting this recommendation, the Prison Service commented: "A notice is to be issued to all staff regarding appropriate documentation."

- A formal process for monitoring referrals to the forensic psychologist should be in place and prisoners on the 'waiting list' should be reviewed on a regular basis by the multi disciplinary team to identify if their needs have changed.

  The Prison Service accepted this recommendation and stated the following: "Referrals discussed at weekly multi-disciplinary meeting. All referrals should be generated by another healthcare professional. The patient will remain on the referrer's caseload until seen. Outstanding referrals to be subject to review on a bi-weekly basis initially. This process to be reviewed after two months and reduced to monthly if appropriate."

- Care should be taken when a prisoner's medical records are not available, especially if significant alterations to medications are being made.

  This was accepted by the Prison Service.

- The standard of record keeping in prisoners' medical records should be regularly audited against relevant guidelines.

  The Prison Service accepted this and commented that: "Documentation audit to take place at three-monthly intervals. Defensible documentation training to be delivered as per training plan."

117. The houseblock is a large wing, but despite this man being a quiet and apparently introverted person, wing staff were caring and appear to have engaged with and monitored him. It appears that the majority of significant interactions between the man and the wing staff were appropriately documented in his wing record. However, staff other than the discipline staff also had significant conversations with the man and none of those was recorded either in his records or in the general wing observation book. I acknowledge that on a large wing, staffed by only two officers, there are practical limits to the amount of information that should be recorded. However:

     I recommend that all staff are reminded of the importance of sharing information about prisoners and that they are encouraged to read prisoners' wing records and the wing observation book. All staff should also be reminded of the importance of documenting all significant interactions with prisoners in their wing records and, where appropriate, the wing observation book.

     The Prison Service accepted this recommendation and noted: "Residential managers have been reminded of the importance of communication and monitor staff compliance. Safer Custody staff monitor ACCT forms to ensure proper recording, particularly relating to meaningful interaction with the prisoner."

118. As a point of note, prisoners should be afforded the opportunity to take outside exercise everyday and the timing of this should not routinely coincide with other essential daily tasks such as taking a shower or collecting an evening meal.

119. On the morning of 20 January, the response to the finding of this man was timely and well handled with all staff aware of the procedures to follow. As a housekeeping point, I would suggest that some thought be given to whether it is possible to find a way to identify those members of staff who may be affected by a prisoner's death but who may not be immediately obvious as being in need of support.

120. The prison's proactive approaches to developing a safe environment and reducing suicide and self harm, such as the Insider and Listener schemes, are to be commended. However, it is inappropriate not to have a resident Listener on a wing whose population are, by definition, vulnerable to feeling isolated and in need of support.

I recommend that a suitable prisoner is identified and trained to act as a Listener for the houseblock and that this is actioned as a matter of urgency.

The Prison Service accepted this recommendation and confirmed that a Listener has now been trained and appointed on the houseblock.

121. The man's family were told of his death in a sensitive manner and the prison's Family Liaison Officer has maintained regular contact with the family. I would, however, emphasise the need to inform a family of a prisoner's death as soon as is possible.

Recommendations

1. **I recommend that consideration is given to the following findings, as outlined in the clinical review:**

- A consensus about the treatment of depression should be established in consultation with prison pharmacists and prison GPs. This should include a review of appropriate evidence based medication and the length of time needed for the chosen drug to be effective.

- There should be a review of the referral process to the mental health team with the aim of establishing a robust system with clear referral criteria. This should incorporate the creation of an audit trail to allow healthcare professionals to track the progress of patients and safeguard against patients being lost in the system. A policy should be established which would remove the onus on the patient to re-engage with the Mental Health In-reach Team when they may be experiencing episodes of mental distress.

- A common formulary for prescribing anti-depressants should be maintained, and monitored by prison medical staff at defined intervals.

- If a referral from the wing is received and contact cannot be made then this should be recorded in the IMR and also within the prisoner's wing records.

- If staff have been concerned that a prisoner may be at risk of self harm but subsequently make a decision not to instigate ACCT procedures, it should be clear from the prisoner's records why that decision has been made.

- A formal process for monitoring referrals to the forensic psychologist should be in place and prisoners on the 'waiting list' should be reviewed on a regular basis by the multi disciplinary team to identify if their needs have changed.

- Care should be taken when a prisoner's medical records are not available, especially if significant alterations to medications are being made.

- The standard of record keeping in prisoners' medical records should be regularly audited against relevant guidelines.

2. **I recommend that all staff are reminded of the importance of sharing information about prisoners and that they are encouraged to read prisoners' wing records and the wing observation book. All staff should also be reminded of the importance of documenting all significant interactions with prisoners in their wing records and, where appropriate, the wing observation book.**

3. **I recommend that a suitable prisoner is identified and trained to act as a Listener for the houseblock and that this is actioned as a matter of urgency.**