

**Investigation into the circumstances surrounding the  
death of a man in hospital while in the custody of HMP  
Blakenhurst in October 2006**

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

**November 2007**

This is an investigation into the death of a man found hanging in his cell at HMP Blakenhurst on 5 October 2006. He was due to appear at a Magistrates' Court in Wales that morning. Staff successfully resuscitated the man and he was transferred to the local hospital. The man remained in hospital in the Intensive Therapy Unit for four days with his family around him. On 9 October, his family agreed that the life support machine should be turned off. The man was pronounced dead at 5:55pm that day.

I hope that this report will go some way to providing comfort for the man's family and answer some of the questions that they had about his care in prison. I extend my sincerest sympathy to his wife and five children.

The investigation was carried out on my behalf by an investigator from my office. The clinical review formed a critical part of the investigation and I would like to thank the reviewers, who were appointed by Worcestershire Primary Care Trust (PCT). I would also like to thank the Governor of Blakenhurst at the time of the investigation, and the investigation's appointed liaison officer for the timely support that they gave to this investigation.

My report contains a number of recommendations for the prison to take forward following the man's death. In particular, I raise concerns over the emphasis on the importance of what a prisoner says about his suicidal intent above the many other risk factors that may be present. The man's death was the third self-inflicted death at Blakenhurst prison in 2006.

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

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## SUMMARY

The man had been in prison before, but when he was remanded to HMP Blakenhurst in September 2006 it was his first time in custody for five years. As a man to whom family was very important, he told other prisoners that he was concerned about how his time in prison would affect them. He had deliberately stayed away from his family home so that his children did not see his arrest by police.

The man was never subject to suicide prevention measures while he was Blakenhurst. No mental health assessment was undertaken throughout the time he spent at the prison. A nurse assessed him at reception on 13 September 2006 and identified that he was an alcoholic, he had involvement with a community psychiatric worker and had been prescribed anti-depressants in the community. The man also told the nurse that he had taken an attempted overdose while in police custody, days before the interview. He went on to say that he did not have any further thoughts of self-harm and she felt that he made good eye contact during their interview. The nurse did not therefore assess the man as at risk of suicide or self-harm. She did not follow the procedure specified in the first reception healthscreen form and failed to refer the man for a mental health assessment as she should have done.

The doctor's subsequent examination focussed on the man's physical health needs, although the doctor did note his mental health record. Still no referral for a mental health assessment was made. After a further court appearance two days later, escort staff alerted prison staff to the man's suicide attempt whilst in police custody. The nurse in the reception area on this occasion asked the man about this attempt but he told her that the information she had was not true and he had no thoughts of self-harm. These three healthcare professionals seemed to have looked only at the man's immediate presentation, rather than considering all of his risk factors. All judged him not to be at risk of suicide or self-harm.

The man was moved onto the induction unit and then the voluntary testing unit. He seemed to settle well. Neither staff nor other prisoners thought that he was feeling low or suicidal. On the afternoon of 4 October, the man's cell mate moved cells. The man was due to appear at Cardigan Crown Court on 5 October. He had told other prisoners that he was anxious about the court appearance, especially because he would not have any cigarettes for the journey. After spending the night alone in his cell, the man was woken for his court appearance and told that he was a handover prisoner. (This meant that it was unlikely that he would return to Blakenhurst for that day and he needed to pack all of his belongings.) Initially, he seemed angry about this news and got straight back into bed. Then he appeared to begin to get himself ready for court. However, when staff returned to his cell to unlock him for his court appearance, they found the man hanging from an upended table. Staff attempted resuscitation, and paramedics arrived to transport him to hospital.

The man was taken to hospital, where he remained for four days on a life support machine. With his family's agreement, the man's life support machine was turned off on 9 October 2006 and he died at 5:55 pm.

While I am critical of the initial medical assessments that took place, I am satisfied that the man seemed to settle into life at Blakenhurst. I make three local recommendations about the initial assessment procedure. Although staff felt well supported after the man's death, I have made two other recommendations aimed at improving the support systems available to staff following a death in custody.

In addition, I was disappointed at the length of time that it took for the funeral expenses to be paid to the family, and at the apparently informal approach to family liaison at Blakenhurst, and have made three recommendations.

I have made three recommendations about the emergency response systems at Blakenhurst and one recommendation about night staff's duties.

## **THE INVESTIGATION PROCESS**

I appointed one of my investigators to conduct the investigation into the circumstances surrounding the man's death. She visited Blakenhurst in the days following the man's death to collect his prison records and clinical files. Notices were sent to the prison to invite prisoners and staff to contact the lead investigator with any information that thought was relevant to the investigation. No one responded to this invitation.

Worcestershire Primary Care Trust (PCT) appointed two healthcare professionals to conduct a review into the clinical care that the man received while he was at Blakenhurst. I would like to thank the clinical reviewers for their contribution to the investigation process and for the comprehensive review which has been so valuable to this report.

After a thorough review of the paperwork, the lead investigator visited Blakenhurst many times between October 2006 and January 2007 to interview staff. She was joined by the clinical reviewers to conduct joint interviews with healthcare staff. During the course of the investigation, the lead investigator also met with Bromsgrove police to discuss their findings.

One of my family liaison officers was accompanied by the lead investigator on a visit to the man's wife in the Midlands. His wife discussed her concerns about the man's care at Blakenhurst. I trust that I have addressed these issues in this report.

## **HMP BLAKENHURST**

As a local prison, Blakenhurst serves many courts in the West Midlands area. Its population consists of both remand and sentenced prisoners, and the population is ever-changing. Last year, Blakenhurst opened a new residential unit, which increased the number of prisoners it could accommodate to 1,070.

The most recent inspection at Blakenhurst was carried out unannounced by Her Majesty's Chief Inspector of Prisons at the end of 2005. The Chief Inspector recognised that, "Blakenhurst operates within a very tight budget, and with very light staffing levels". She suggested that "mental health provision was particularly good" in the healthcare department. She found that the substance misuse team "provided a generally good service", although "alcohol abuse provision was restricted to detoxification and weekly Alcoholics Anonymous meetings".

At the time of The Chief Inspector's visit, Blakenhurst had identified Suicide and Self-harm Prevention as an absolute priority following seven self-inflicted deaths between the start of 2003 and July 2004. The Safer Custody team was reported to be well-resourced and represented at a senior level in the prison. This is still the case. However, although there were no apparently self-inflicted deaths at Blakenhurst in 2005, there were three in 2006 including the man's death.

## KEY FINDINGS

The man was remanded to Blakenhurst on 13 September 2006. His usual solicitor was not in the office on 13 September. Another solicitor was present at Warwick Crown Court instead and left before the hearing had taken place.

The man had expected to be arrested and had arranged to stay at a friend's house just before his arrest. He did not want his children to see him being arrested. When he was taken into police custody on 11 September, the man tried to take an overdose.

During a first reception healthscreen on 13 September, the man told the nurse that he had taken an overdose on 11 September, while in police custody. (A first reception healthscreen is an interview by healthcare staff that takes place when a prisoner arrives at the prison for the first time. It should determine any physical or mental health conditions that require treatment, any substance misuse matters that need to be addressed and any risk that the prisoner may pose of harming himself or attempting suicide.) The man's healthscreen noted that he had been diagnosed with depression, had a psychiatric care worker, and had been prescribed anti-depressants in the community. In the Substance Use section, the man told the interviewer that he drank 8-10 cans of strong cider on a daily basis before he was arrested. According to the clinical review, 8-10 strong cans of cider might contain as much as 29-36 units of alcohol. The man also said that he smoked cannabis. The man told the first reception healthscreen nurse that he had no thoughts of self-harm at the time of the interview. The man was not referred for a mental health assessment. The nurse did not assess him as being at risk of suicide or self-harm and so did not commence the formal monitoring system. Following the healthscreen, the man was referred to a doctor about his physical health and at his own request.

The man saw a locum doctor working at Blakenhurst within twenty minutes of the first reception healthscreen. The doctor told my investigator that he was happy with the way that the healthscreen was carried out by the first reception healthscreen nurse. The clinical review records that:

“The GP's assessment noted the mental health history but focussed on the prisoner's physical health needs.”

The locum doctor's entry in the clinical record concentrated on the Plaster of Paris on the man's arm (from an injury that he had sustained before his arrest). The locum doctor was concerned with ensuring that the man maintained links with the outside hospital that had treated him for his arm injury.

Assessment, Care in Custody and Teamwork (ACCT) is the system used at Blakenhurst and at every other prison to monitor and support prisoners who are at risk of harming themselves. Any member of staff who has contact with a prisoner can raise an ACCT form if they are concerned that he or she might be at risk of self harm or attempted suicide. Risk factors listed in 'The ACCT Approach' guidance document for prison staff include “alcohol/drug misuse” and “recent suicide attempt”. No ACCT form was raised after the first reception healthscreen. During interview, the first reception healthscreen nurse said:

“The gentleman that was sat in front of me, with a Plaster of Paris on his arm wasn’t what I would have considered a high suicide risk at that time. Yes he told me that he took an overdose, whether that was because he knew he was going to be arrested and that was his way of getting out I don’t know.”

The nurse said that, had the man been “displaying bizarre behaviour”, for example, “twitching getting up and down, quite agitated” or “if there was no eye contact, withdrawn, low”, then she would have been concerned about his mental health. My investigator put the following statement to her:

“[The man] drank a significant amount of alcohol and that was then to be dealt with by the GP, the previous day he’d attempted overdose as he told you and there is a community psychiatric nurse in the community and you weren’t quite clear of the context of that. With all of that information, and how he presented to you on that day, you were satisfied that he wasn’t at risk of suicide or self harm.”

The nurse confirmed that this was her conclusion.

A Cell Sharing Risk Assessment was completed and the man was assessed as a medium risk to others. Concerns about self-harm were recognised and the following entry was made by the first reception healthscreen nurse:

“O.D. taken 11.09.06 but states not thoughts of self harm at this time.”

The man was located in a shared cell on the induction unit.

The man’s usual solicitor was present for his second appearance at Warwick Crown Court on 15 September. The man told his solicitor that he had taken an overdose while in police custody. In light of this, she and a member of the court custody staff became concerned about his state of mind. They were particularly worried because the man had his arm in a sling which could be considered a potential ligature. The solicitor advised the court staff of his attempt at suicide and pointed out that the sling was a potential ligature. She asked court custody staff, “to make a note on [the man]’s file that he had made a suicide attempt, that he was not receiving painkillers for his arm or any treatment for his arm and he had not seen a psychiatrist.”

As a result of the court appearance on 15 September, the man was remanded to Blakenhurst again. Court staff raised a self-harm warning form and passed it to the prison escort staff who transferred it to the prison the same day. On the Prisoner Escort Record for this court appearance, escort staff had made the following entry:

“Informed by solicitor that [the man] attempted to hang himself on Tuesday 12/9/06.”

(This was a likely misinterpretation of what the solicitor had actually said to court staff.)

When the man arrived at reception, escort staff passed the self-harm warning form to the senior officer who supervised the reception area of the prison. Although he did not specifically recall receiving the man's self-harm warning form, the reception senior officer told my investigator that he would always pass such forms to the nurse in the reception area and ask that the prisoner be interviewed by the nurse.

On that occasion, the senior officer asked the nurse in reception to speak to the man. She met with him and the man assured her that he had no intention of self-harming and that he was "feeling ok within himself". The nurse told my investigator that she did not receive the self-harm warning form until halfway through the appointment when an officer walked into the private room where the man's interview was being conducted and passed her the form. When she asked him, he said that it was "not true" that he had tried to hang himself. The nurse looked at the end of the first reception healthscreen and noted that the man was not on an open ACCT document or deemed to be at risk. She did not look through the first reception healthscreen document and therefore did not see the reference to the man's attempt at overdose or his daily intake of alcohol. The man did not tell the nurse that he had taken an overdose while in police custody. During interview, the nurse in reception said that she asked the man whether he had any thoughts of self-harm or suicide, why staff might be concerned about him and whether he would like her to make a mental health referral. In response, the man said that he was fine and that he did not want to be referred for a mental health assessment. The nurse in reception told my investigators that she would have raised an ACCT form had she known about the man's previous suicide attempt. However, she did have the first reception healthscreen with her at the time. Nevertheless, she did not probe the man about why someone might have said that he had attempted suicide if he had not. The self-harm warning form was put in his medical file. The nurse advised him to make a medical appointment if he felt low at any time. The man was not made subject to ACCT procedures.

The man was located on the induction unit. (Every prisoner at Blakenhurst goes through the induction programme, which includes an introduction to the regime of the prison and the prison facilities, for example the gym.) He seemed to settle well on the induction unit and no concern was raised by staff or prisoners about his mental state.

On 24 September, the man was moved from the induction unit to houseblock 4. Any prisoner at Blakenhurst can apply to be placed on houseblock 4, which is a voluntary drug testing unit. Prisoners who apply to be placed on this houseblock either do not take drugs, or have a history of substance misuse and want support to remain drug and alcohol free. All prisoners on this houseblock are subject to regular drug tests.

The man was drinking a significant amount of alcohol on a daily basis before he was remanded to Blakenhurst. However, he did not receive any medical treatment for detoxification from alcohol throughout his time in prison. He had asked the prison for help with his "drink problems". On 27 September, he was interviewed by a member of the CARATs team. ('CARATs' stands for Counselling, Assessment, Referral, Advice and Through Care Services. It is a nationwide treatment programme for prisoners who have misused drugs or alcohol.) During the interview, the man admitted that he had used cannabis in the month before going to prison. He told the

CARATs worker that he consumed alcohol daily and that he drank in excess of 50 units of alcohol a week. The CARATs worker was concerned about the man's previous heroin addiction and said that it was not uncommon for previous heroin addicts to go on to become alcoholics. The CARATs worker told my investigator that he left the man with a booklet named "Cutting Out – A guide for drug users". Although the CARATs worker could not specifically recall if he was worried about the man during the interview, he said that he would not have given the booklet to someone he thought to be at risk of suicide or self-harm. He described it as a hard-hitting document that he would only give to robust prisoners. From this, he could deduce that he was not concerned about the man's state of mind.

An undated fax was sent from the CARATs team to 'DIP SPOC' which stands for Drugs Intervention Programme, Single Point of Contact. (A Drugs Intervention Programme is an agency in the community that will give support to substance misusers. CARATs teams often work in partnership with DIPs, to ensure that the support that a prisoner gets in custody is continued when they are released into the community.) The message on the fax was, as follows:

"[The man] has asked for help with alcohol issues. Refd to you due to past heroin use. He has been clean for a number of years."

There is no record of further correspondence with the DIP on the man's CARATs file. The man did not meet with the CARATs team again although he was located on houseblock 4 where the CARATs team is based. The CARATs worker said that it can take around two weeks to get an appointment with CARATs, but he was often stopped by prisoners on houseblock 4 and would happily chat to them informally about their care plan. He did not recall speaking to the man after their first meeting on 27 September.

The man was not employed at Blakenhurst. He was not a member of any particular classes. Despite being located on houseblock 4, he did not attend the weekly Alcoholics Anonymous group that took place on the unit. He spent a lot of time on the houseblock. As a voluntary testing unit, my investigator was told that, in general, houseblock 4 was a quieter, more stable part of the prison. Prisoners had more time out of their cell, associating on the landings.

Blakenhurst has the facility to monitor prisoners' telephone conversations. All telephone calls are taped. When the man died, the tapes of his last telephone conversations were retrieved and summaries were written which were passed to my investigators with the man's files. All of the summaries relate to phone calls that were made on 28 September. He had made several attempts to contact his wife. When the man spoke to her, he asked if she was going to visit. She told him that she would visit on the following Sunday (8 October). His wife said that his sons were looking forward to seeing their dad. The final call was the man leaving a message on his wife's answer machine at 7:51pm on 28 September. He told her that "he loved her and would hopefully see her Sunday".

One of the man's outstanding criminal matters was being dealt with at a Magistrates' Court, some 150 miles from Blakenhurst. He was due to appear there on 5 October. He was then due to appear on a separate matter the following day in Crown Court.

On 1 October, the man made a general application to conduct his Cardigan Magistrates' Court appearance by videolink. (General applications are forms filled in by prisoners to request a variety of services, for example, an appointment with CARATs or education staff. General applications are made by prisoners on the houseblock. Houseblock officers sort through the applications every morning and pass them to the relevant department.) The general application for the man's case to be heard by videolink was passed to the custody department, which deals with the co-ordination of court appearances and sentence calculation. An executive officer in the custody department, sorted through the applications that her department had received that morning. She noticed the man's application because it related to a court appearance that was due to take place in a couple of days time. For that reason, she dealt with the application herself as a matter of priority. The executive officer contacted Cardigan Magistrates' Court and checked that the man was due to appear on 5 October. Staff at the court confirmed that his case was scheduled for 5 October. When the executive officer asked whether the man could appear via videolink, given his court appearance scheduled for the following day, staff said that there was no videolink facility at the court. The executive officer sent a note of her findings to the man via the internal post system. When asked in interview, the executive officer could not confirm that the man had received that note, but it was likely that it had reached him by 4 October.

A couple of days before his court appearance, the man spoke to a fellow prisoner on houseblock 4 with whom he was distantly related during association. They spoke about the upcoming court appearance in Cardigan Magistrates' Court. The man told the prisoner that he had been charged with possession of a quad bike and burglary. He said that he was not guilty of burglary and that there would be no evidence against him. The man thought he might get a maximum of 12-18 months in prison for possession of the quad bike. He said that, if he was not sentenced to prison on the Thursday at Cardigan Magistrates' Court, he would be released on the Friday at Warwick Crown Court. Another prisoner on houseblock 4 told police that the man had said he was expecting his case at Cardigan Magistrates' Court to be adjourned. The man's wife told the lead investigator that the man had thought he would be released following his appearance at Warwick Crown Court.

The man's cell mate shared his cell over the last week of his life. The cell was a small cell on the third landing, with a pair of bunk beds and a small table in the corner. The man told his cell mate that he was anxious about his court appearance. He did not want the long journey in the escort van and was concerned that, being away on the day of the court appearance, he would not be at Blakenhurst to receive his canteen. The man was worried about the prospect of travelling to Wales without any cigarettes. In statements taken by the police following the man's death, the cell mate said:

“we chatted quite a lot. He was quite a talkative person and seemed to be ok and as happy as could be expected ... He did not mention anything about wanting to take his own life ... I am aware that [the man] was detoxing from alcohol and cannabis but he seemed to be ok with everything and fairly pleased to be putting weight on.”

The man's cell mate applied to be moved to another cell that became available on 4 October. He told the police that he wanted to move cells because he thought that the other cell was more spacious. He did not apply to move cells because he was unhappy sharing with the man, he thought they got on well. The cell mate's application was approved and at 4:30pm on 4 October he moved to another shared cell straight away. By default, the man was left alone in the double cell that night.

Blakenhurst's suicide prevention strategy states that for at-risk prisoners who are subject to ACCT procedures:

"Shared accommodation is generally preferable to a single cell"

It goes on to say that:

"... single cell accommodation may be used ... in this case there must be a higher frequency of staff support."

The man was not deemed at risk of self-harm or suicide. Therefore, he was not reviewed when his cell mate left the cell that afternoon nor given any additional support.

At 8:30pm, the night Operational Support Grade (OSG) assigned to Houseblock 4 started his night shift. When he started his shift, all of the prisoners were already locked in their cells. At 9:00pm, he went round to each of the cells as usual to check if they were locked. The OSG told the police that it was not his responsibility to check the prisoners' welfare. He spent most of the shift completing paperwork in the office, occasionally disturbed by prisoners on the houseblock calling him to their cells by ringing a cell bell.

At around 1:00am, the OSG got a list of prisoners who were due to appear in court on 5 October. There were three prisoners on the list, including the man. He made a note of their cell numbers but did not contact the prisoners or alert them to their court appearance in any way. He told my investigators that it was normal practice to receive the court lists at around this time during the night shift. He also said that prisoners do not expect to hear that they are appearing in court until the morning of their appearance. The man was marked as a 'handover' on the court listing. The OSG explained that, as a 'handover', the man was not expected to return to Blakenhurst after his court appearance. It was likely that he was marked as such because he was due to appear at Cardigan Magistrates' Court, some distance from Blakenhurst.

At around 6:15am, the OSG began his round of the houseblock to wake those prisoners due to appear in court that day. He recalled that he went to the man's cell, knocked and opened the observation panel on the cell door. The man came to the window where the OSG informed him that he should pack his belongings because it was not likely that he would return to Blakenhurst that night. The OSG told the man that reception staff would collect him for his court appearance. He remembered the man moaning about not returning to Blakenhurst that day as he climbed back into his bed. The OSG said that this was a typical response from prisoners who rarely wanted to go to court.

The OSG shut the observation panel and went to wake the other prisoners for court. Around 15 to 20 minutes later, the OSG returned to the man's cell and looked through the observation panel. He recalled that the man was standing in the cell with clothes on, although the OSG could not remember if the man was wearing his nightwear or was ready for court. The OSG said that he assumed he was getting ready to go to court, and asked him if this was the case. The man replied that he was getting ready for court. The OSG remembered the man as being "bright and alert". He thought that he was not "in a state to self-harm". The OSG did not unlock the man's cell door at any time that morning. He returned to the houseblock office and awaited the reception staff.

Two officers were scheduled to work in the reception area of the prison on the morning of 5 October. One of these officers began his shift at 6:30am and the other started fifteen minutes later. As part of their role as reception officers, they prepare prisoners who are due to appear in court to be escorted from the prison. They collect prisoners from their cell and take them to the reception area. On the morning of 5 October 2006, they made their way to houseblock 4 first. They spoke with the OSG who told them that the man had initially said that he did not want to go to court, but had changed his mind and was getting ready. The second reception officer went to 'C' spur, and the first reception officer went to 'A' spur where the man was located. During interview, the first reception officer said that he thought the man might have needed a bit longer to get ready for court because he had initially refused to get up, so he made his way to a cell on the second landing and found the other prisoner was ready. The first reception officer unlocked that prisoner and made his way to the area on the landing where prisoners wait to be taken to reception. The officer then went to the man's cell on the third landing. He did not know the man, but understood from the court list that he was due to appear in court in Wales on 5 October.

The officer unlocked the man's cell door. He saw the man hanging by a ligature around his neck. The ligature was made from a strip of bed sheet that had been tied around the metal bracket of an upturned table. The table was placed on the top of two bunk beds. The officer said that the man was not moving and he thought he might be dead. He supported the man's weight and called for the second reception officer to assist him. By this time that officer had unlocked the prisoners on 'C' spur and had returned to the staff office. He heard the shout, "Help!" and could see the first reception officer standing at the end of the landing, one floor above him. The second reception officer immediately ran up the flight of stairs and reached the man's cell, "in about 10 seconds". While he was on his way, he heard the first reception officer make a 'Code Yellow' radio call. ('Code Yellow' is the code used at Blakenhurst for a medical emergency. It summons the orderly officer and healthcare staff to attend the scene.) This call was made at 6:55am. The OSG also heard the Code Yellow. He walked out of the staff office onto the landing. When he looked up, he saw the first reception officer with a prisoner hanging. The man's cell was near the end of the spur, towards the centre of the houseblock where the staff office is located. It is possible to see into cells up a flight of stairs from the staff office. The OSG immediately went back into the office to make a telephone call to the communications department "to outline the seriousness of the situation and advise them that an ambulance would need to be called". It was recorded on the communications log that the ambulance was called at 7am exactly.

When the second reception officer entered the cell, he noticed that the man was “motionless” and was “very pale”. He untied the knot that was fixed to the table. The officers jointly brought the man to the floor. The second reception officer untied the ligature from behind the man’s neck and checked the man’s vital signs. The man was not breathing so he commenced cardio-pulmonary resuscitation (CPR). The second reception officer moved to the doorway of the man’s cell and radioed to check that healthcare staff were on their way. He was told that they were. The orderly officer arrived with another officer shortly after the second radio call had been made. The other officer stood outside the cell. The orderly officer entered and assisted the first reception officer to continue with CPR. The orderly officer recalled that he applied chest compressions, while waiting for healthcare staff to arrive. The first reception officer told my investigator that he was performing mouth-to-mouth while the orderly officer applied chest compressions.

There was one staff nurse in the healthcare centre at the time that the radio call was made. He was ‘Hotel 1’ for the night shift. (‘Hotel 1’ is the term used to call the designated member of healthcare staff to attend a medical emergency.) During a night shift, healthcare staff do not carry keys to enable them to move around the establishment. The nurse had to wait to be collected and escorted to the man’s cell. While he waited, he gathered medical equipment and waited on the upper landing of the healthcare centre. He was collected and, accompanied by a healthcare assistant, made his way quickly to houseblock 4. Around eight minutes after the radio call, the nurse arrived at the man’s cell with the “red bag” that contains first aid equipment for cuts and bruises. The nurse also had the defibrillator. He then asked the officers to stop CPR briefly while he checked the man’s vital signs and applied the defibrillator. He found no vital signs and the defibrillator showed that the man should not be shocked. The nurse said that the man was pale in colour. He asked for the oxygen to be brought from the houseblock office and he and the orderly officer started CPR again until the paramedics arrived.

The ambulance staff arrived at 7:17am. They took over the resuscitation efforts momentarily and then transferred the man to the ambulance. Two officers escorted the man out of the prison. The risk assessment stated that the man did not need to have restraints used on him, “however duty governor to be contacted if medical situation changes”. The ambulance left the prison at 7:45 am. Some staff reported that it took two minutes to get through security at the prison gates and others said that it took ten minutes. The man finally arrived at the Accident and Emergency Department at Queen Alexandra Hospital at 8:05am.

Upon arrival at the hospital, the man had a Computerised Tomography (CT) scan. He was treated and transferred to the Intensive Therapy Unit (ITU) at 9:45am. The man’s wife was told what had happened by officers from her local police station. She made her own way to the hospital with their two sons at 10:35am.

Two prison officers were deployed to watch the man as he was still in Blakenhurst’s custody. At 8:30pm that evening, the duty governor instructed the staff on bedwatch to withdraw from the private room where the man was located when his family was present. He told bedwatch staff that they must return to the room when the family

left. A review of the required staffing levels for the man's bedwatch took place on 6 October:

“As the condition of the prisoner is so serious, a review has taken place and the staffing of this bedwatch is to be reduced to one officer with immediate effect.”

Over the next three days, the man's condition remained critical but stable. He did not regain consciousness. A prison officer was always present throughout his time in hospital. His wife said that, in general, she did not speak to the prison officers but found that one was helpful by making her tea and coffee and being generally supportive during the time that the man was at hospital. That officer spoke to the man's wife at length on 7 October and advised her to speak to the Head of Security at Blakenhurst. She had several questions for the prison and the officer thought that the Head of Security would be best placed to answer them. The man's wife was particularly grateful to the officer for his support at that time.

At 5:00am on 9 October, another bedwatch officer was informed by a nurse that the man's condition had deteriorated badly and was told by hospital staff that “it's not looking good”. He was taken for a further CT scan at 11:00am that morning. Following the scan, the doctor spoke to the man's wife and asked her to consider withdrawing his treatment. The doctor and police liaison officer sat with the man's wife during the morning, and then her sister-in-law arrived. At this difficult time, a different officer was on bedwatch duty. At 4:00pm, the officer withdrew to the staff room out of respect for the family who were understandably in considerable distress. The man's family waited by his bedside until his two sons got to the hospital at around 5:30pm. The bedwatch officer was informed by a doctor that the man had died at 5:55pm that evening after the life support treatment was withdrawn.

In accordance with his instructions, the officer contacted Blakenhurst to notify staff of the man's death. The orderly officer in charge at that time informed the Governor and the Care team.

### **Staff Support**

There was no hot debrief following the man's death. (A hot debrief is a meeting held directly after a serious event like a death in custody or serious attempt at self harm to establish the sequence of events and whether any immediate lessons can be learned). Staff who had been involved with the response efforts on the morning of 5 October were not told when the man had died, but found out through their own initiative or informally. During interview, some staff members felt that “it would have been nice” to have been told about the man's condition and to have been notified when he had died. A debrief is a vital opportunity for staff to share what happened and identify if any lessons can be learned immediately. On this occasion, arrangements should have been made to communicate the man's condition with those staff involved with his care.

**The Governor should ensure that debriefs are held following every serious attempt at self-harm.**

## **The Governor should ensure that systems are in place to inform staff following a death in custody.**

The Head of Healthcare at Blakenhurst, held a meeting with healthcare staff following the man's death. During interview, she described:

"I actually took copies of [the man]'s IMR [Inmate Medical Record] to the staff, just after he died and I sat in the staff room. I did it both in Primary Care which is upstairs and Lower Medical staff and I gave them the copies and I said okay tell me what's wrong or what's right with this medical record, let's have a look and almost, I wouldn't like to say it was supervisory it was a reflective practice."

The Head of Healthcare told my investigator that the exercise was not done to apportion blame, but to look at what went well with the man's care at Blakenhurst and what could be learned for the future. I welcome this initiative.

While he was in hospital, at least one prison officer was with the man at all times. These officers told my investigator that they had been well-briefed and felt well-supported by the prison. They were told not to speculate when they were speaking with the family and that the Head of Security, was to be the single point of contact for the family's questions. All staff were told that this was to discourage speculation and ensure the accuracy of information that the family were given.

All staff told my investigator that they knew who the staff care team were and how to access them. No member of staff felt that they did not receive the support that they needed following the man's death.

### **Family issues**

On 6 November, the lead investigator visited the man's wife, accompanied by the a family liaison officer from my office. The purpose of the visit was to explain the investigation process and to give the man's wife the opportunity to raise any concerns that she might have about his care while he was at Blakenhurst.

The man's wife was concerned about the way that the news was broken to her. She was told by local police that her husband was in hospital. She said that the police did not arrive at her home until 12:30pm. She said that the prisoner who was distantly related to the man had tried to contact her just before the police had spoken with her. The man's wife was concerned that she was not the first to know what had happened to him. The duty governor recalled that the hospital took some time to confirm the man's condition, which had to be clarified before the family could be properly informed. There are no precise records surrounding the notification of the family of the man's serious self-harm and whether it was co-ordinated by the police, the prison or the hospital.

**The Head of Safer Custody must ensure efforts are made to contact the next of kin as quickly as possible about any serious incident of self-harm.**

The man's wife was also concerned that no one visited her in person and that she not offered transport to the hospital, some 35 miles away from her home. While it is regrettable that prison staff did not break the news to the man's wife themselves, I believe the prison was properly concerned that she needed to learn what had happened to her husband as quickly as possible in order that she could attend the hospital to be with him without delay.

The man's wife made her way to the hospital where she was greeted by the appointed family liaison officer. The man's wife told my investigation team that she did not meet the governing Governor until two days after he had been taken to hospital, when he was still on a life support machine. She said that the Governor and the chaplain had attended the hospital and were nice during their visit. She did not feel that the prison had much contact with her since.

No one at Blakenhurst was trained in family liaison in October 2006. Although the prison appointed the Head of Security, in practice much of the family liaison has been conducted by the Chaplain. The Head of Security arranged for the family to visit the prison and see the cell where the man had died. Unfortunately, the man's wife told the lead investigator that she was still unclear about how the man had died following this visit. She would have liked to know exactly how her husband died before she visited his cell.

**The Head of Safer Custody should ensure that there is at least one appropriately senior member of staff trained in family liaison.**

The man's wife said that she had been told that she would receive funeral expenses. Regrettably, the prison did not pay these expenses until January 2007 due to a mislaid invoice.

**The Governor should implement a more robust system for the payment of funeral expenses following a death in custody.**

The man's wife asked the lead investigator to speak to the prisoner who was distantly related to the man and the prisoner he shared a cell with until the evening of 4 October. She was concerned that both of these prisoners were moved to other prisons, seemingly with no notice, the day after the man had been taken to hospital. My investigators met with both of these prisoners who agreed that they were not expecting to be transferred on 6 October. They felt that the timing of their transfer might have had something to do with the man's death.

The lead investigator spoke with two executive officers from the Observation, Classification and Allocation (OCA) office at Blakenhurst. This office is responsible for the allocation of prisoners for completion of their sentence plan. One of them explained that there is a running list of prisoners at Blakenhurst who have been sentenced but are awaiting the appropriate documentation required for transfer to a training prison where they can complete their sentence plan. She said that there are normally between 10 and 12 prisoners on the list. Due to overcrowding among the general prison population, as soon as the necessary documentation arrives the prisoner is taken on to a training prison to complete their sentence plan to make space for new prisoners. Staff who work in the OCA do not meet prisoners as part of

the allocation process. Staff are given no notice as to when to expect the documentation and therefore cannot give a prisoner notice of their transfer. Prisoners should be made aware that they will be transferred in due course as part of the sentence planning process. The executive officers confirmed that they did not know the man, his cell mate or the prisoner to whom he was distantly related. They did not meet either prisoner as part of their transfer allocation process. I am satisfied that the timings of the transfers, although unfortunate, were coincidence and not connected to the man's death.

The man's wife was also concerned about the treatment that the man received for his depression while at Blakenhurst. She remembered him telling her that he was not given his prescription anti-depressants and she thought that he was finding it difficult to cope. However, the man told the first reception healthscreen nurse that he had been prescribed anti-depressants in the community but did not take them. There is no record that he complained about feeling depressed or made a medical application to see a doctor about depression.

### **The Clinical Review**

The clinical reviewers were appointed by Redditch and Bromsgrove Primary Care Trust to examine the clinical care that the man received while he was at Blakenhurst. (During the course of the investigation, Redditch and Bromsgrove PCT merged with a neighbouring PCT and became Warwickshire PCT, as it will be referred to from now on in this report.) The clinical reviewers considered the man's clinical records and ACCT document and conducted some joint interviews with my investigator.

The clinical review concludes that, in retrospect, it is possible to see that the man was at a heightened risk of attempted suicide. The clinical reviewers go on to say:

"Though several opportunities could have identified the prisoner to be at heightened risk of self-harm, none triggered a response. This suggests that systemic rather than individual error is present."

The clinical reviewers make eight recommendations:

**We recommend that the PCT's provider arm ensures that there is a comprehensive and rapid training of healthcare staff on ACCT; and that the PCT's commissioning arm is assured that timely and systematic training of prison healthcare staff is being carried out.**

**We recommend that the PCT's provider arm clarifies clinical responsibility in the prison healthcare service; and that the PCT's commissioning arm is assured that it is understood who in the multidisciplinary team has overall responsibility for the patient or acts as their key worker.**

**We recommend that the PCT, in determining its organisational structure, makes clear the distinction between responsibility to commission and to provide healthcare at the prison, and that appropriate management information and measures of service delivery are reported for accountability.**

**We recommend that the prison encourages and supports training of custodial staff in first aid and resuscitation and ensures the availability of face masks for CPR.**

**We recommend that the PCT's provider arm renews its efforts to improve record keeping and documentation; and that the PCT's commissioning arm is assured that measurable progress is being made.**

**We recommend that consideration is given to increasing the service available to prisoners with severe alcohol problems and that a detoxification service is available to those who need it, as we understand is available in local prisons elsewhere. We recommend that healthcare staff are given training to better recognise alcohol problems in prisoners and to recognise where support should be provided.**

**We recommend that the prison reviews the use of 'Code Yellow' so that code calls give healthcare staff better information about the urgency and nature of the incident to which they are being called.**

The clinical reviewers recognised the following three areas of good practice:

**Prison staff administered CPR to the prisoner while healthcare staff were making their way to the scene.**

**Prison staff were equipped with ligature knives.**

**Healthcare staff showed judgment in recognising Body Mass Index (BMI) and referral accordingly and in taking a defibrillator to the scene.**

## ISSUES

### ***Was the man's initial medical assessment appropriate?***

According to Blakenhurst's suicide prevention strategy:

"The link between drug withdrawal, detoxification, mental health issues and suicide is significant."

The man arrived at Blakenhurst on 13 September and a healthscreen was completed that day by the first reception healthscreen nurse. The healthscreen recorded that the man had attempted an overdose while in police custody, he drank between 29 and 36 units of alcohol daily, he was under the supervision of a psychiatric care worker and that he had been prescribed anti-depressants in the community. Despite these significant risk factors, the nurse did not open an ACCT. During interview she said she did not consider him a high suicide risk (I have quoted her exact words earlier).

The nurse said that she did not ask the man about his overdose in any detail because the questions on the first reception healthscreen form did not prompt her to. She told my investigator that she had no training in detoxification and relied on a poster on the wall to determine how many units of alcohol each drink contained. The nurse said that she was not mental health trained, but that she could make a referral to a mental health worker "based on her own judgement". She was not trained in the ACCT process but she had been trained in the previous suicide and self-harm system in use at the prison and had been working at Blakenhurst for four years. The nurse said that she opened around ten ACCTs a week in the reception area and she was confident about using the ACCT process. During interview, the first reception healthscreen nurse said that she balanced the risk factors identified through the screening against the way that the man presented to her during the interview. She said that she would have referred him to a mental health nurse if he had displayed "bizarre behaviour" or seemed "withdrawn". She said that she would have opened an ACCT, "if there was any doubt at all". She told my investigator that she was confident that the man was not a risk of suicide or self-harm at that time.

Blakenhurst's Strategy for suicide and self-harm underlines:

"Research has shown that the early period in custody is the time of greatest risk of suicide and self-injury. Good reception, first night, detoxification and induction procedures provide greater opportunities to identify and care for those prisoners at heightened risk this is therefore paramount."

In retrospect, I am a little surprised that there was "no doubt" in the nurse's mind that the man was at risk of self-harm, especially given his overdose attempt two days before the healthscreen. I am concerned that healthcare staff who carry out reception healthscreens are not trained in the current suicide prevention system at Blakenhurst. I understand the pressures that training courses place on staffing levels. However, as Blakenhurst's own strategy document points out, the opportunity presented for the healthscreen to effectively determine a risk of suicide and self-harm is "paramount".

**The Head of Healthcare should ensure that all healthcare staff are trained in ACCT procedures over the next six months.**

The man told the first reception healthscreen nurse that he was drinking a significant amount of alcohol daily. During the consultation for the draft report, the man's wife explained that although the man had problems with drugs, she did not consider him an alcoholic. However, he told staff that he drank 10-12 cans of strong cider daily, which means that, clinically speaking, he is classified as an alcoholic and should have received relevant treatment. The man also sought support for his alcohol misuse while he was at Blakenhurst.

During interview, the nurse seemed unsure of the amount of units in each type of alcoholic drink. She said that there were no detoxification nurses at Blakenhurst and that she did not feel confident in assessing someone's substance misuse needs. It is of concern that Blakenhurst do not appear to have a systematic approach to the healthcare provision for prisoners going through detoxification. I agree with the clinical reviewers' recommendation:

**The Governor and the Head of Healthcare, working with Warwickshire PCT, must increase the service available to prisoners with severe alcohol problems and ensure a detoxification service is available to those who need it. Healthcare staff must be given training to better recognise alcohol problems in prisoners and to recognise where support should be provided.**

As well as opening an ACCT, the first reception healthscreen nurse could have made a mental health referral. She did not. The 'Mental health' section of the first reception healthscreen is made up of three questions, questions eight, nine and ten. Question eight is whether the prisoner has ever received treatment from a psychiatrist outside prison. The man's response to this was, "yes", he had been treated by a psychiatrist for depression. Question nine asks the prisoner if he has ever received medication for any mental health problem. The man's answer was again "yes", although he could not remember what the medication was called. (He remembered that it began with a 'c'.) Question ten asks the prisoner if he has ever tried to harm himself. Again, the man said "yes", that he had tried to harm himself outside prison by overdosing on 50 tablets of Naprosyn (a painkiller) two days previously. At the end of the 'Mental health' section of the healthscreen, the following message is written in bold:

**"If "yes" recorded to Questions 8, 9 or 10 (outside prison) refer for mental health assessment."**

During interview, the first reception healthscreen nurse told my investigator:

"Like I say, the things I have omitted there, I would have normally have put. If I wasn't going to do a mental health referral, I would have put why I didn't feel it was necessary at that time and I haven't. I can't think back to the day, all I can think is maybe there were fifteen waiting in the waiting room, I don't know."

According to the form, the matter was not left to the nurse's discretion. If any one of the questions were answered positively then she was instructed to make a mental health referral. It was a procedural mistake not to do so.

The locum doctor saw the man twenty minutes after this healthscreen. The clinical reviewers said that he "noted" the man's mental health history but focussed on the physical symptoms that he presented, that is the injury to his arm. The man told the doctor he was feeling okay. The doctor did not make a mental health referral or open an ACCT document following his assessment.

No referral was made for a mental health assessment. This meant that the man's mental health was not properly assessed by anyone in the prison. No one got in touch with the psychiatrist who had seen the man in the community to discover his mental health history. Finally, the decision not to place him on an ACCT document or refer him for a mental health assessment affected the reception nurse's assessment of the man's risk of suicide or self-harm two days later on 15 September.

The reception nurse on 15 September looked at the self-harm warning form passed to her by reception staff which had incorrectly recorded that the man had attempted to hang himself on 12 September. The man's solicitor, told my investigator that "at no time did I say to the custody staff that [the man] had attempted suicide by hanging". The solicitor had told court staff that the man had said he had taken an overdose while in police custody. She went on to raise concern about a sling that he was wearing to support his right arm and was concerned that he might try to use this material as a ligature. When the reception nurse asked the man whether he had tried to hang himself as the self-harm warning form suggested, he rightly said that he had not. The nurse told my investigator that she did check the last page of the healthscreen document and was satisfied that the man had not previously been assessed as at risk of attempted suicide or self-harm. She did not read the whole of the healthscreen document, only the last page, which indicated that there was no need for a mental health referral and no concerns about self-harm or detoxification. During interview, she said of the overdose:

"If I had known about it I would have put him on an ACCT form but I didn't know anything about it."

The nurse had the man's medical record with her. Had she read through the healthscreen, she would have seen the risk factors that the first reception healthscreen had identified. This was an opportunity missed.

The system appears to have let the man down. Neither the two nurses nor the doctor seemed to look beyond the man's immediate presentation. The first reception healthscreen nurse did not follow the first reception healthscreen instructions about a mental health referral. The doctor focussed primarily on physical problems instead of being more holistic in his approach. The reception nurse on 15 September did not seem to explore the information given to her on the self-harm warning form.

**The Head of Healthcare should remind nursing staff to take into account a prisoner's medical record, first reception healthscreen and other relevant**

**information, as well as discussions with the prisoner, when assessing the risk of suicide and self harm.**

My investigator spoke to one of the man's two personal officers during the course of the investigation. He explained that as the man's personal officer he would speak to the man occasionally. During interview, he said:

“It can be hard to operate a personal officer system because when officers do a week of night shifts, the following week is taken as rest. The same officers work on the same spurs, so often prisoners will approach an officer on the spur rather than particularly their personal officer.”

In the personal officer's view, the man did not appear down. The officer thought that the man was settled on houseblock 4 despite not having been there long, and he seemed to chat to everyone. He seemed to make friends easily and it was the personal officer's impression that he was not shy and would not have had trouble approaching staff with concerns. He did not notice whether the man attended Alcoholics Anonymous and he was unaware that the man was a heavy consumer of alcohol. The personal officer did not know of any self-harm attempts.

The man's other personal officer did not meet him while he was at Blakenhurst due to annual leave and shift patterns. Although there is personal officer training for new officers, it is brief and they are not prescriptive procedures.

The man spoke to a couple of prisoners on the landing about his upcoming appearance in the Magistrates' Court in Wales. He was facing charges of burglary. He felt that if the court appearance went well, he was likely to be released following his next court appearance in Warwick Crown Court. The man seemed to be most anxious about not having any cigarettes for his journey to court. He had applied to have the hearing via videolink but the Magistrates' Court does not have a videolink facility. The man's wife told my investigator that the man would have found it difficult to be so far from home for that court appearance. He was concerned that he would lose touch with his family who were in the Midlands area if he found himself in a prison in Wales. It was when the man was told that he was a 'handover' prisoner (a prisoner who was not expected to return to Blakenhurst after his court appearance) that he reacted badly on the morning of 5 October.

The staff nurse assessed the man as fit for his court appearance on 5 October. He explained the process to my investigator during interview as a "sift" exercise. The nurse who does the night shift will go through the medical records of all of the prisoners due to transfer out of the prison, either for a court appearance or because they are transferring to another establishment. The staff nurse explained that he did not meet the man to assess him as fit for court. He said that he read his inmate medical record, but he did not think that there was any reason to highlight him as a problem for transfer.

When asked if he took the opportunity to look at the appropriateness of the man's care, the nurse responded that, at the time that he reviewed the man's record, his risk was no longer "current". He said that no further entries had been made in the man's medical record while he had been at Blakenhurst, and he had no intelligence

to suggest that he was a risk of self-harm. By the time the staff nurse assessed him, there was simply no information available about how well he was or was not coping with prison life.

In conclusion, the man was going through a withdrawal, he had attempted an overdose in the days before arriving at the prison, his mental health was being treated in the community but had not been assessed in prison. In retrospect, this information suggests that he should have been placed on an ACCT during his initial period in custody at Blakenhurst. That said, the man then appeared to settle onto the residential unit and gave no indication to staff or his fellow prisoners that he was feeling low or potentially suicidal.

### ***Would it have made a difference if he were on an ACCT?***

If the man had been made subject to ACCT, he would have been more closely monitored by healthcare staff and staff on the houseblock. He would have been better supported through his mentally and physically demanding detoxification from alcohol. The man would also have been involved in regular multi-disciplinary meetings to determine his level of risk and asked to engage in a support plan to manage his risk factors. The multidisciplinary meetings would have encouraged communication so that all staff could have been made aware of his attempted suicide just prior to custody and his continuing risk factors.

According to Blakenhurst's suicide prevention strategy for prisoners on ACCT:

“Shared accommodation is generally preferable to a single cell ... Single cell accommodation may be used if the prisoner presents a risk to others or where personal space is of particular importance to the individual ... IN THIS CASE THERE MUST BE A HIGHER FREQUENCY OF STAFF SUPPORT.”

In this section of the strategy document, Blakenhurst recognise the importance of company for someone who is having thoughts of self-harm or suicide. The man was located on his own in a cell on 5 October when he attempted to take his life. His cell mate moved out the evening before. If the man had been subject to ACCT procedures, it may have been recognised that this was a time of particular risk because of his concerns about the upcoming court appearance.

However, even if an ACCT had been opened on 13 or 15 September, it was just as likely to have been closed following reviews after one or two weeks. It is impossible to determine whether the decision not to open an ACCT document during the reception process directly contributed to the man's suicide two or three weeks later.

Whilst not connected to the man's suicide attempt on the morning of 5 October, I was concerned by the comments of the OSG about his perceived role and responsibilities during a night shift at the prison.

During interview, the OSG said that on 4 October he carried out his usual check at 9:00pm after coming on duty and that this check was to see if the cells were locked. The OSG told the police during his interview with them that it was not his responsibility to check the prisoners' welfare. The initial 'check' by the oncoming

night member of staff is most usually a count of every prisoner on the unit and a check that they are all okay. It is not a 'cell door check' not a 'lock check' but a physical count and check of all the prisoners on the wing.

I am also troubled that the OSG does not think he is responsible for checking on prisoners' welfare. Unit-based staff are a crucial part of the system in place to ensure the welfare of prisoners during the night. They are most usually the people tasked with carrying out ACCT checks, and with responding to cell alarm bells which may be activated because of an emergency situation. The OSG told my investigator that he carried out ACCT checks and responded to cell bells.

**I ask the Governor to ensure that night staff are reminded of their true role and responsibilities at night and that they receive training and written guidance where necessary.**

***When the man was discovered in his cell on 5 October, were response efforts timely and appropriate?***

When the first reception officer walked into the man's cell, he immediately shouted assistance. The second reception officer made his way immediately to the cell. The first reception officer used his radio to call a 'Code Yellow'. At this point, the OSG ran onto the houseblock to see what was happening. As soon as he had realised the seriousness of the situation, he returned to the office where he used the telephone to call the communications department. He requested an ambulance. In my view, the response at this stage was urgent and appropriate.

The second reception officer supported the man's weight, while the second reception officer undid the ligature knot. In Prison Service Order 2700, (the national instruction that governs the management of suicide and self harm prevention across the Prison Service), staff are encouraged to "preserve the knot if possible". If the knot can be preserved, it can help provide useful evidence if there is any doubt that the ligature was made by the prisoner's own hand. The second reception officer said that he carries an anti-ligature knife, as did all prison officers at Blakenhurst at that time. However, due to the looseness of the ligature knot, he judged that it would be quicker to undo the ligature knot, rather than cut the ligature with his knife. I think that the decision to undo the knot rightly placed the preservation of life over the preservation of evidence.

At the time of the man's death, prison officers nationally were not required to carry ligature knives, although it was thought to be good practice. I agree with the clinical reviewer and commend the policy that all prison officers carry anti-ligature knives. (In November 2006, the Prison Service made it a mandatory requirement for all prison officers to carry anti-ligature knives.)

The staff nurse was not carrying keys. When he heard the Code Yellow, he knew he was required to attend but did not know what medical emergency he was attending. He said:

"It could be anything from heart attack, epileptic fit to someone has cut their finger. Basically you don't know what you are going to so it's basically it could

be anything. It's always been a problem for quite a few years in the prison because it might just be the fact that you are going to something that could be walked to medical, you don't know what equipment to take."

The nurse said that the lack of information about the nature of emergency has sometimes meant that incorrect equipment was taken and staff have had to return to healthcare to collect more equipment. The nurse said that he used his experience of the prison environment and his intuition when deciding to take the defibrillator with him to this particular emergency. He said that:

"At that time in the morning if someone, because people do die in their sleep, and that sort of scenario goes on and here we know we just need the extra checks just to make sure and the assistance, certainly with heart attacks you need a defibrillator to kick start it."

It was a sound judgement that the staff nurse took the defibrillator with him. However, I agree with the clinical reviewer that:

**The Governor should review the emergency radio code system. Code calls should give healthcare staff better information about the urgency and nature of the incident to which they are being called.**

The orderly officer heard the Code Yellow radio call when he was at the main gate of the prison about to handover to the orderly officer for the morning shift. He made his way immediately to houseblock 4. When he got to houseblock 4, he entered the cell and immediately checked the man's vital signs. His impression was that the officers in the cell had not started first aid, but he could not be sure. He commenced chest compressions but did not administer mouth-to-mouth because he did not have a one-way mouth valve (known as a resusci-aid). In fact, the first reception officer told my investigator that he had started CPR by the time that the orderly officer arrived. He said that he started mouth-to-mouth. He did not use a resusci-aid to perform mouth to mouth. Staff do not routinely carry resusci-aids with them, although they were available in the first aid kit located in the houseblock staff office. Chest compressions administered without mouth-to-mouth are not effective, because oxygen is not being circulated in the patient's blood. This underlines the importance of the availability of resusci-aids for staff, so that they are trained and ready to perform full CPR when necessary. I agree with the clinical reviewer:

**The Governor and the Head of Safety and Decency should consider issuing resusci-aids to staff as standard.**

In general, staff reported that the ambulance passed through the main gate without delay. However, the orderly officer said that he was surprised to find the ambulance still in the gate area of the prison when he went to leave the prison at the end of his shift. During interview, he said:

"I said to the SO who was on the Gate, I said why isn't it going? He said we are waiting for a Gate Pass. I said it's a blue light that should have gone straight through. So I don't know, that's out of my hands."

The one of the escorting officers told police that when he was in the ambulance that took the man to hospital, he recalled waiting for around ten minutes in the gate area of the prison. When my investigator spoke to him, the officer reported that there was a missing risk assessment but that only caused a delay of one or two minutes at the gate. I agree with the orderly officer that there should be no delay in the ambulance leaving the prison. There was no video footage available to verify the amount of time that the ambulance spent in the gate.

**The Head of Security should devise a system to ensure the swift departure of an emergency ambulance.**

***Was the man's bedwatch carried out appropriately by staff?***

While he was at Alexandra Hospital, he was still in prison custody. Before his medical condition had been determined, two members of staff were detailed to carry out the bedwatch. The man was located in a private room in the intensive therapy unit. That evening, bedwatch staff were instructed by a governor to withdraw from the room in order to afford the family some privacy. However, when the family left the room, they were to return to the room to carry out the bedwatch supervision.

The following day, the decision was taken by a governor, to reduce the number of staff required to a single officer for the bedwatch duty. The man's wife said that she found it difficult to speak to most of the officers who were with the man in those last few days. She said that they could not offer her any more information about what had happened to her husband. I think that officers were acting, as instructed, in the best interests of the family by deferring to one point of liaison for the man's family. Mixed messages or misunderstandings arising from officers guessing at what had occurred could have led to more distress for the family.

I therefore feel that the bedwatch was carried out appropriately by the prison.

## RECOMMENDATIONS

I have made nine recommendations:

**The Governor should ensure that debriefs are held following every serious attempt at self-harm.**

**The Governor should ensure that systems are in place to inform staff following a death in custody.**

**The Head of Safer Custody must ensure efforts are made to contact the next of kin as quickly as possible about any serious incident of self-harm.**

**The Head of Safer Custody should ensure that there is at least one appropriately senior member of staff trained in family liaison.**

**The Governor should implement a more robust system for the payment of funeral expenses following a death in custody.**

**The Head of Healthcare should ensure that all healthcare staff are trained in ACCT procedures over the next six months.**

**The Head of Healthcare should remind nursing staff to take into account a prisoner's medical record, first reception healthscreen and other relevant information, as well as discussions with the prisoner, when assessing the risk of suicide and self harm.**

**I ask the Governor to ensure that night staff are reminded of their true role and responsibilities at night and that they receive training and written guidance where necessary.**

**The Head of Security should devise a system to ensure the swift departure of an emergency ambulance.**

I have discussed and agreed with three of the clinical reviewers recommendations in this report:

**The Governor and the Head of Healthcare, working with Warwickshire PCT, must increase the service available to prisoners with severe alcohol problems and ensure a detoxification service is available to those who need it. Healthcare staff must be given training to better recognise alcohol problems in prisoners and to recognise where support should be provided.**

**The Governor should review the emergency radio code system that code calls give healthcare staff better information about the urgency and nature of the incident to which they are being called.**

**The Governor and the Head of Safety and Decency should consider issuing resusci-aids to staff as standard.**

The clinical reviewer has made a further five recommendations:

**We recommend that the PCT's provider arm ensures that there is a comprehensive and rapid training of healthcare staff on ACCT; and that the PCT's commissioning arm is assured that timely and systematic training of prison healthcare staff is being carried out.**

**We recommend that the PCT's provider arm clarifies clinical responsibility in the prison healthcare service; and that the PCT's commissioning arm is assured that it is understood who in the multidisciplinary team has overall responsibility for the patient or acts as their key worker.**

**We recommend that the PCT, in determining its organisational structure, makes clear the distinction between responsibility to commission and to provide healthcare at the prison, and that appropriate management information and measures of service delivery are reported for accountability.**

**We recommend that the prison encourages and supports training of custodial staff in first aid and resuscitation.**

**We recommend that the PCT's provider arm renews its efforts to improve record keeping and documentation; and that the PCT's commissioning arm is assured that measurable progress is being made.**

The clinical reviewers identified three areas of good practice:

**Prison staff administered CPR to the prisoner while healthcare staff were making their way to the scene.**

**Prison staff were equipped with ligature knives.**

**Healthcare staff showed judgment in recognising Body Mass Index (BMI) and referral accordingly and in taking a defibrillator to the scene.**

I would like to pass on the man's wife's thanks to the bedwatch officer who provided some support for her while her husband was in hospital.