

A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

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**Investigation into the circumstances surrounding  
the death of a man in November 2012 at HMP Hewell**

## ***Our Vision***

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

This is the report of an investigation into the death of a man at HMP Hewell in November 2012. He was 38 years old. He was found hanging in his cell eleven days after he was sentenced to a hospital order and moved to Hewell pending a transfer to hospital. I offer my condolences to his family and friends.

The investigation was carried out. A review of the clinical care which the man received in prison was undertaken by a clinical reviewer. The prison cooperated fully with the investigation.

The man had significant mental health problems when he arrived at HMP Birmingham in February 2012. However, during the next few months his condition seemed to stabilise and his medication appeared to be helping. He was expected to receive a hospital order and was placed on a medical hold so that he would remain at Birmingham and maintain continuity of care. However, this was not recorded on his escort documents and he was taken to Hewell after appearing at a different court on 2 November.

We share the clinical reviewer's serious concerns about aspects of the man's care after he transferred. At first he was located in the inpatient unit for observation, which appeared to be a sensible precaution in light of his circumstances. However, his request to see a substance misuse worker was overlooked. Later, he was moved to ordinary prison accommodation without any discharge plan or referral for further help from the mental health team. No explanation for his discharge was recorded. Three days later he asked a nurse for a mental health assessment but the nurse completed a referral form without an adequate consultation.

Although it would have been difficult for staff at Hewell to foresee the man's actions, I agree with the clinical reviewer that the care he received at Hewell was well below the expected standard. There were a number of significant and unacceptable failures in the care of a prisoner with serious mental health issues. Indeed, weaknesses in his care appear to reflect a wider malaise in the management of the inpatient unit at Hewell. These individual and collective failings require urgent remedial action.

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

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

**July 2013**

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## SUMMARY

1. The man had a history of mental health problems and had spent time in prison before. In February 2012, he seriously assaulted his father. He was arrested, taken to court and remanded into custody at HMP Birmingham. He was twice subject to self-harm monitoring but was prescribed medication and began to improve. He saw a mental health nurse every fortnight and regularly saw a consultant psychiatrist.
2. In August, the man was found not guilty of his offence by reason of insanity. The Crown Court commissioned psychiatric reports which recommended that he receive a hospital order and should be transferred to a secure hospital for treatment. He was placed on medical hold at Birmingham until the court case was completed. He appeared at Crown Court on 2 November after his hearing was moved there. He received a hospital order and was to be transferred from prison to hospital within 28 days. He was taken to HMP Hewell as the instruction that he should remain at Birmingham until his transfer to hospital had not been recorded on the documentation that accompanied him to court.
3. When the man arrived at Hewell, the duty governor instructed the GP in reception to admit him as an inpatient. Four days later, the senior nurse in charge of the inpatient unit discharged him to a houseblock. Another nurse made a brief entry in the medical record to indicate that he had moved. There was neither an explanation recorded for the discharge nor a referral to the mental health team.
4. The man moved to another houseblock three days later. On 9 November, he asked a nurse for an appointment with the mental health team. The nurse completed a referral form but did not interview him to make an informed initial assessment. He was not reviewed by a member of the mental health team before he died.
5. A few days later, the man spent most of the day in his cell. In the morning he was supposed to have a regular depot injection of his prescribed anti-psychotic medication but this did not happen and there is no record to explain why. He was locked in his cell at 2.15pm. At about 3.45pm, two prisoners looked in his cell by chance, saw that he had hanged himself and raised the alarm. Officers attended, cut him down and performed chest compressions. They called for further assistance. Nurses took over until paramedics reached the cell but he could not be revived. The prison GP pronounced him dead at 4.17pm.
6. It is regrettable that the medical hold at Birmingham failed. The initial caution shown in admitting the man as an inpatient at Hewell was sensible. However, we are concerned that he asked to see a substance misuse worker but no referral was completed. His discharge four days later was not properly documented and there was no care plan and no appropriate mental health support or referral to the mental health team. When he later asked to see someone from the mental health team, a routine referral was made but we are

concerned that the nurse completing the referral did so without accurately assessing him.

7. The investigation and clinical review found that staff in the healthcare unit were unsure of their roles and responsibilities. We agree with the clinical reviewer that improvements are needed in the running of the healthcare unit. We make six recommendations as a result of the investigation.

## **THE INVESTIGATION PROCESS**

8. The investigator visited HMP Hewell on 19 November and met the Governor, Principal Officer, the investigation liaison officer and the duty governor on the day of the incident. He visited Houseblock 2, where the man died, and interviewed five prisoners. He also visited the healthcare centre. He collected relevant records. He also met the Chair of the POA, the prison officers' union.
9. The local PCT commissioned a clinical reviewer to undertake a review of the clinical care the man received in custody.
10. The investigator returned to Hewell on 12 December to conduct seven interviews. He was accompanied by the clinical reviewer and gave verbal feedback to the Governor. On 17 January 2013, they conducted two further interviews at Hewell. On 24 January, they conducted two interviews at HMP Birmingham and four at Hewell. The investigator subsequently interviewed a nurse by telephone. They returned to Hewell on 14 February to conduct one further interview. The investigator gave further written and verbal feedback to the Governor of Hewell.
11. A copy of our report has been sent to the local Coroner.

### **The man's family**

12. One of our family liaison officers contacted the man's family to discuss our investigation.
13. The man's mother wanted to know if her son was on his own in a single cell when he died. We can confirm that he was because he was assessed as being a high risk to other prisoners. She was concerned that her son was not kept in the healthcare centre at Hewell until he could be transferred to hospital and asked whether he had received the correct medication.
14. The man's father thought that he was too mentally unwell to be in prison and wanted to know the circumstances of his son's death. He did not believe that he would have taken his own life. He was concerned about the care his son had been offered in Hewell.
15. The man's partner wanted to know why he was transferred from Birmingham to Hewell as this was disruptive for him and would have caused him additional stress. She wanted to know whether he was subject to any monitoring when he died. He was not. She asked what his mood was like. There is little information about this in the days before his death. She wanted us to explain what happened when he was found hanging in his cell. She asked whether his medication was appropriate and whether he was seen by mental health trained staff.
16. The man's brother asked about the involvement of a senior mental health nurse in his care. He asked whether his brother had assaulted prison officers.

He did at the start of his time in custody at Birmingham but there is no evidence that he assaulted staff at Hewell. The man's brother asked for more information about his medication. He thought that his brother should have been subject to self-harm monitoring and asked for more details about what happened on the day he died. The man's brother is a prisoner and believes that his brother would have coped better if they had been located together.

17. The man's family were provided with copies of our draft report during the consultation period. They have spoken to our family liaison officer about the investigation. They did not identify any factual inaccuracies that required changes to this final version of the report.

## **HMP HEWELL**

18. HMP Hewell is a grouping of three pre-existing prisons on the same site (formerly HMP Blakenhurst, HMP Brockhill and HMP Hewell Grange). Hewell primarily accepts prisoners from courts in the West Midlands, Worcestershire and Warwickshire. Houseblocks 1 to 6 hold a maximum of 1074 men in closed conditions. Houseblock 7, the former Brockhill has been decommissioned and Houseblock 8, the former Hewell Grange, holds 187 men in open conditions. The man lived in the healthcare centre and on Houseblocks 6 and 2 of what was previously HMP Blakenhurst. The inpatient healthcare centre has 18 beds. The mental health team treat any prisoner with a mental health disorder, including the more severe illnesses such as schizophrenia.

## **Her Majesty's Inspectorate of Prisons (HMIP)**

19. HMIP most recently inspected Hewell between 5 and 9 November 2012, while the man was a prisoner there. Inspectors commented:

'There are significant concerns about HMP Hewell whose performance has deteriorated sharply since our last inspection. Much of the prison provided an unsafe and degrading environment for staff and prisoners alike... The prison was unacceptably dirty – appallingly so in some places.

'... at the time of this inspection the prison had no clear sense of direction, some staff appeared to lack motivation, and in some areas poor practice had been left to develop unchallenged... the inspection identified a number of significant concerns and the new governor faces a major challenge in reversing the slide in the prison's performance.

'Not all recommendations related to deaths in custody were being addressed.

'Over ten vacancies [in the healthcare department] were causing some disruption to the delivery of services, but this was being addressed.

'The in-patient unit was well equipped and cells were adequately furnished. Prisoners were very complimentary about the unit and their care.'

## **Independent Monitoring Board (IMB)**

20. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that proper standards of care and decency are maintained. The most recent annual report published by the Independent Monitoring Board (IMB) at Hewell covers the year from December 2010 until November 2011, in which the Board highlighted the difficulty in recruiting sufficient healthcare staff.

## **Previous deaths at Hewell**

21. None of our investigations in the last two years at Hewell have raised any issues which are similar to the circumstances of the man's death.

## KEY EVENTS

### HMP Birmingham

#### 7 February – 2 November

22. The man had been to prison before. He was known to the Birmingham Adult Public Protection Unit (PPU) and his local community mental health team (CMHT). On 5 February 2012, he was charged with grievous bodily harm with intent against his father. After his arrest, he made threats to harm himself at the police station. He was remanded into custody at court and taken to HMP Birmingham on 7 February. During the reception process, he was assessed by a nurse and a doctor.
23. A nurse began Assessment, Care in Custody and Teamwork (ACCT) self-harm monitoring on 9 February after the man smashed a television and said that he was feeling suicidal. The same day, mental health staff obtained from his CMHT two different diagnoses of either paranoid schizophrenia or dissocial personality disorder coupled with drug induced psychosis. A nurse spoke to the police, Birmingham Adult PPU and his doctor. She discovered that he had not been taking his antipsychotic medication for several months.
24. A mental health nurse assessed the man on 10 February. He reported an extensive history of crack cocaine and heroin use. He did not want to move to the healthcare centre and the nurse did not think it was necessary. A doctor prescribed olanzapine (an antipsychotic) and staff planned to book him an appointment with a psychiatrist.
25. Later that day, the man attacked an officer without provocation. He was taken to the Care and Separation Unit temporarily and then moved to the healthcare centre. He continued to behave aggressively but reluctantly agreed to be admitted. Because of his volatile behaviour he was unlocked only when the other patients were in their cells.
26. Healthcare staff continued to seek advice from the man's community psychiatrist. From 14 February, he was allowed to mix with other prisoners. His ACCT document was reviewed the next day. A consultant psychiatrist stopped prescribing olanzapine as he had refused to take it.
27. Mental health staff held a discharge meeting and drew up a discharge plan for the man's care. He left the healthcare centre on 17 February. His ACCT observations were increased slightly while he adjusted to life back among the general prison population. As he was assessed as a risk to other prisoners he was given a single cell. ACCT monitoring continued until 20 February. The mental health nurse who attended the final ACCT review did not observe any overt signs of mental illness.
28. On 22 February, the man destroyed property in his cell overnight. On 24 February, a doctor prescribed him olanzapine again. In early March, he again caused concern and would not engage with staff. After he damaged property

in his cell again, he was admitted to the healthcare centre on 3 March. After his admission, he constantly demanded tobacco. His mood alternated between pleasant and aggressive. The healthcare staff asked his community psychiatrist to visit him. On 7 March, a psychiatrist continued the prescription for olanzapine and also prescribed zopiclone to help him sleep. He thought that his schizophrenia was in remission and that he was probably suffering from a personality disorder with narcissistic and borderline traits.

29. On 9 March, a mental health nurse saw the man and thought he might be psychotic. She completed a new care plan. His mood continued to deteriorate when he did not have tobacco, and he became demanding and abusive. On 12 March, she updated his care plan. Later that day he threatened to kill staff.
30. On 14 March, healthcare staff received the man's medical records from his GP and CMHT. On 20 March, staff discovered that he had carved the word 'Allah' on his body. He threatened to cut himself again if he did not get tobacco. Staff began a second period of ACCT self-harm monitoring and checked him at least once an hour.
31. A consultant psychiatrist reviewed the man on 22 March. He thought that the man was mentally well. He said that his recent deliberate self-harm was to get attention and he did not have suicidal thoughts. The psychiatrist prescribed citalopram for anxiety and depression. He did not consider that there was a clinical reason to keep him in the healthcare centre, so he recommended he be discharged. Staff continued ACCT monitoring.
32. Healthcare staff held a discharge meeting on 27 March and prepared a discharge care plan. The man agreed to return to the general prison population that day. The second ACCT was closed on 30 March. Staff completed daily post-closure checks on him from 31 March until 6 April.
33. On 4 April, a mental health nurse updated the man's care plan. He would be seen every fortnight by a mental health nurse from the mental health in-reach team and continue his medication.
34. On 11 April, the man's psychiatrist from the community reviewed him with a mental health nurse. The psychiatrist confirmed that the man had a history of poor compliance with his medication. He recommended routine drug screening and a referral to the forensic mental health team (who treat prisoners with severe and enduring mental health problems who have also committed serious offences and therefore present a higher risk). He also recommended that the man be prescribed pregablin (a pain killer which prison GPs had previously refused to prescribe because there was no clinical need), pericyazine (an antipsychotic) and zopiclone (a sedative). The psychiatrist recommended that he should continue taking citalopram but that olanzapine should be stopped and replaced with an antipsychotic depot injection.
35. A doctor reviewed the man on 3 May with a mental health nurse and considered the community psychiatrist's recommendations. He stopped the

prescription for olanzapine and started risperidone (a different antipsychotic). He thought that the man might in the future move to a depot injection (which slowly releases medication into the body over a number of weeks). He decided not to prescribe pregablin, zopiclone or pericyazine. The man was calm and the doctor thought that he was making good progress.

36. The man attended Crown Court on 21 May. His keyworker reviewed him on 30 May and he said that the risperidone was helping. He saw her again on 13 June and appeared at Crown Court again on 19 June. A doctor reviewed him on 21 June. He increased his dose of risperidone and prescribed a fortnightly depot injection of risperidone consta (an antipsychotic drug). The doctor thought that he was making excellent progress and that his daily combination of risperidone and citalopram was proving effective. He was a lot calmer, was working as a wing cleaner and was no longer demanding other drugs.
37. A nurse administered the man's first depot injection on 26 June. He attended Crown Court again on 29 June. His keyworker gave him his second depot injection on 10 July. He told her that he had no plans to harm himself and was feeling less paranoid. As his keyworker, she completed his care plan the same day.
38. The man's next depot injection was on 24 July. He was anxious about his court case and worried that his mental health would deteriorate and he might harm somebody again. His keyworker reassured him that if he moved to another prison after sentencing, she would liaise with their mental health in-reach team (MHIRT). He made further appearances at Crown Court on 26 and 30 July.
39. When a nurse gave the man his next depot injection on 7 August, he was anxious and stressed. He rated his own mood as 2 out of 10 and the nurse booked him an urgent appointment with a psychiatrist for the next day. He told the doctor that he wanted to cut himself. The psychiatrist thought that his psychotic symptoms were worsening because of the impact of his ongoing court case. He prescribed zopiclone for two weeks to help him sleep. He recorded an elevated risk of self-harm but the man said he had no current intention of harming himself. Staff did not begin self-harm monitoring at this stage. The psychiatrist planned to review him after sentencing.
40. The man's keyworker reviewed him on 9 August. He was extremely anxious about his forthcoming court case. She tried to reassure him and booked him an appointment with the doctor to discuss his medication. He appeared at Crown Court on 14 August where there was a special verdict of not guilty by reason of insanity. He was remanded into custody again to await the court's disposal decision. Two psychiatric reports had already been prepared, but the court commissioned further reports.
41. The keyworker gave the man another depot injection on 21 August. He was still anxious so she booked him an appointment with a psychiatrist. He was discussed at a multi-disciplinary team (MDT) meeting the same day. The next day, prison staff completed a new cell sharing risk assessment (CSRA) and

decided that he should remain in a single cell because of his previous aggressive behaviour.

42. On 23 August, a psychiatrist referred the man from the mental health in-reach team to the forensic team. The forensic team accept patients who are likely to receive a hospital order, as had been recommended in his case. His keyworker was now a forensic mental health nurse.
43. A consultant forensic psychiatrist, who visits from the Raeside medium secure unit every Thursday afternoon to hold a forensic psychiatric clinic, reviewed the man the same day. She discussed him with a nurse and they prescribed procyclidine (to reduce the side effects of his antipsychotic medication).
44. The man was assessed by a forensic psychiatrist on 30 August. He thought that he seemed rational and his mood was appropriate. He advised that he maintain his current antidepressant and antipsychotic medication but add promethazine (which acts as a sedative).
45. On 4 September, a nurse gave the man his regular depot injection. He was still nervous about what the court would decide, but he had recently moved wings without incident and had a job. On 6 September, a psychiatrist wrote in the clinical record that he was feeling much better. He was having suicidal thoughts but was trying to stay positive. She diagnosed that he was currently in partial remission from paranoid schizophrenia. She amended but continued his prescriptions for citalopram and procyclidine and decided to recommend his transfer to a secure hospital.
46. On 18 September, a nurse stopped the man's prescription for procyclidine at his request after consulting her colleagues. She administered his depot injection which had just been increased by a psychiatrist. Although he was now under the care of the forensic team, the nurse, who worked for the in-reach team, continued to see him at her fortnightly clinic as the in-reach team was responsible for administering his depot injection. To prevent him being transferred to another prison and disrupting his continuity of care before a possible transfer to hospital, she asked the medical secretary to place him on medical hold. The next day, the secretary put an alert on the front page of his electronic clinical record to this effect, stating 'not for transfer to another establishment'. This message was given a high priority.
47. The man appeared in court on 21 September, but the psychiatrist's report was not ready so the case was adjourned. On 2 October, a nurse gave him his depot injection. He was having auditory and visual hallucinations and was suffering panic attacks because of his anxiety about his court case.
48. A psychiatrist interviewed the man to complete the court psychiatric report on 8 and 11 October. Staff discussed him at a multi-disciplinary Team meeting on 10 October. A nurse gave him his next depot injection on 16 October. He said that he could not sleep and that he was hearing voices more often. He was still anxious about his court case. He appeared at Crown Court on 18 October when the case was adjourned again.

49. On 30 October, a nurse gave the man his regular depot injection. He told her that his procyclidine was not working. He said that he was pacing his cell, was having panic attacks and was not sleeping. She tried to reassure him that it was normal to feel nervous before sentencing.

### **The Court's Decision**

50. The man appeared at Crown Court on 2 November. He had previously appeared at another Crown Court, from where prisoners automatically return to HMP Birmingham. However, that day some cases had been moved to this court because the other Crown Court was at full capacity.
51. Healthcare staff have to assess whether prisoners are fit to attend court. The night before, a nurse checks the clinical records of any prisoner making a court appearance the next day and marks the 'Health risks' section of his Person Escort Record (PER) with any relevant information. The PER travels with the prisoner to court to inform escort staff about him. A nurse completed this section of the PER at 10.30pm on 1 November and wrote on it 'mental health issue'. To prevent prisoners on medical hold transferring elsewhere after a court appearance this information is supposed to be written on the PER. This was not done despite the alert on the electronic clinical record.
52. On the morning a prisoner goes to court, a nurse checks him in the reception area before he leaves. The nurse uses the medical section of the PER completed by their colleague the night before and speaks to the prisoner to check if there are any new health problems which might prevent them going to court. A nurse saw the man before he left for court that morning and gave him his medication.
53. A psychiatrist endorsed the existing recommendation of a hospital order because the man had a history of non-compliance in the community and no further useful work could be done in prison. A secure hospital environment was most likely to offer him the long term help he needed to get better.
54. In accordance with the psychiatrist's recommendation, as well as the previous psychiatric reports, the man was made the subject of a hospital order and was detained for inpatient treatment under sections 37/41 of the Mental Health Act 1983. (Once a hospital order is made, the authorities are given 28 days to locate a bed and complete the transfer.) Marlborough House medium secure unit (MSU) near Milton Keynes had agreed to accept him. A psychiatrist from Marlborough House had prepared a court report supporting the previous psychiatrist's recommendation. His detention would have been indefinite and could only be lifted after an application to the Secretary of State.
55. A psychiatrist visited the man in the cells at court. He seemed happy with his sentence and said to her that he was going to get the help that he needed. He mentioned to her that he would likely to be going to HMP Hewell that night as he knew that prisoners automatically went there from that Crown Court.

She reassured him that, if this happened, he would be seen by her colleague from the Raeside medium secure unit, who held a regular clinic at Hewell.

56. The man returned to prison to await transfer to hospital within 28 days once a bed became available. Afterwards, he went to HMP Hewell rather than Birmingham because Hewell routinely take prisoners leaving that Crown Court. Escort staff were unaware of the medical hold for Birmingham, as it had not been marked on the PER.

## **HMP Hewell**

### **2 – 13 November**

57. During the reception process at HMP Hewell, the man was screened by a nurse.
58. The duty governor completed the initial sections of an enhanced risk assessment form because the offence that the man had been charged with indicated that he might need to be considered for potential category A status. Normally prisoners subject to this risk assessment are moved to the segregation unit but, after consultation with the Governor, the duty governor insisted that he go to the prison's inpatient unit because of his hospital order.
59. A doctor reviewed the man in reception and thought that his mood was calm and appropriate. He was polite and friendly and did not seem angry or strange in mood. He appeared stable on his medication. The doctor did not think that there was a clinical need for him to be admitted to the healthcare centre as an inpatient, but he did so, on the duty governor's instruction. He noted in the clinical record that it would be up to the mental health team to review this decision.
60. The man moved into a single cell in the healthcare centre (there are no shared cells in the inpatient unit). An officer completed his induction plan. Based on what he told him, the officer recorded 'detox from subutex' and noted that although he had a history of self-harm, he was not having any current suicidal feelings. He said that he had last harmed himself eight years previously. An officer completed his reception cell sharing risk assessment and initially assessed him as a standard risk for cell sharing, which meant he was regarded as suitable to share a cell.
61. The next day, the man seemed settled and spent most of his time in his cell. He saw a doctor and asked for pain killers as he had previously done at Birmingham for a testicular injury. The doctor prescribed paracetamol. He said that he had been using subutex illicitly at Birmingham. A nurse completed an initial care plan for him on 4 November.
62. On 5 November, the man spoke to the Integrated Drug Treatment System (IDTS) team manager about his need for a detoxification programme. The IDTS team is responsible for the clinical management of prisoners with substance misuse problems. She told the investigator that as she was

passing through the inpatient unit the man asked her if he could see an IDTS nurse. She said she immediately asked her colleague if he would assess him. There is no record of this and no assessment was done that day by the IDTS team, or in the following days. No referral form was ever completed.

63. The same day, as part of a regular review in the days after reception, an officer updated the man's CSRA and changed it to high risk because of his conviction for a violent offence. This meant that he could not share a cell. He telephoned his partner twice. During the day, there was an incident involving other prisoners in the healthcare centre which meant that he was confined to his cell for the day for his own safety. A mental health nurse, who was the manager of the inpatient unit at the time, told the investigator that he seemed to cope well.
64. On 6 November, the man told a member of the Counselling Assessment Referral Advice and Throughcare Service (CARATS), which supports prisoners with substance misuse problems, that he did not wish to engage with them to address his substance misuse issues.

### **Discharge from the inpatient unit**

65. On 6 November, a nurse wrote in the clinical record that the man had been found in another prisoner's cell and he was asked to leave. He was then discharged from the inpatient unit. A discharge plan was not completed and there was no referral to the mental health team (MHT). After his discharge, he moved into cell A3-77 on Houseblock 6, a standard single cell on a general prisoner unit.
66. Later on that same day, an agency mental health nurse noted in the clinical record that the man had been moved to Houseblock 6 as he had been caught wandering into other prisoners' cells in the inpatient unit. She added that he was to be placed in a single cell (because of his risk to other prisoners) and seen by the mental health team. Nobody else made an entry in the clinical record referring to his discharge from the inpatient unit.

### **The inpatients manager**

67. The manager in charge of the inpatient unit was also the senior nurse with responsibility for mental health delivery at Hewell. She explained to the investigator that the man had wandered into the cell of an elderly and immobile prisoner that morning and stolen tobacco from him. He had a longstanding preoccupation with obtaining tobacco. She told the investigator that there were two similar incidents that day that prompted his discharge from the inpatient unit, which was already under discussion. There were concerns about the vulnerability of elderly prisoners.
68. The inpatients manager said that she visited the security department and confirmed that the duty governor had now completed the man's enhanced risk assessment. He was not to be treated as a category A prisoner. He was no longer subject to any location restrictions, and was able to move to a normal

houseblock. The nurse said it was not unusual for prisoners on hospital orders or waiting transfer to hospital under the Mental Health Act to be located elsewhere in the prison.

69. The inpatients manager said she mentioned to her colleagues in the morning that the man would probably be discharged that day. She spoke to him in his cell. She told the investigator that she then discussed the matter with two nurses in the inpatient unit office after lunch. She said that the decision to discharge was taken jointly by the three of them. She had already been thinking of progressing him from the inpatient unit and she said that he was happy to move to a houseblock.
70. She said she told the two nurses that the man could be discharged once the necessary paperwork was completed. She told the investigator that both nurses were responsible for completing a discharge plan and mental health referral as this was their area of responsibility. She could not specifically remember who she had asked to do this.

#### **Nurse A**

71. Nurse A said she did not discuss the man's discharge with the inpatients manager and that she had not spoken to him about it. She said that the manager made the decision to discharge without involving any other nursing staff. She said that the other nurse mentioned at the lunchtime handover meeting that the man had gone into an elderly patient's cell. She said she was still in the office with other nurses when the manager spoke to him with prison officers and discharged him. She estimated that he was discharged at about 2.00pm.
72. The nurse said that the manager did not ask her to complete a discharge plan or mental health referral or make an entry in the clinical record. She stated that the manager did not explain where the man was going and then left the unit without explaining what needed to happen next. She made her entry in the clinical record at the end of her working day because she had seen him pack his belongings and leave the unit but realised there was nothing about the discharge in his clinical record.
73. She said that she had to ask the officers who were moving the man to find out what was happening. They told her that they were taking him to a single cell on the houseblock. She had arranged to leave a little early that day. As she made her entry about him discharge at 3.45pm, she said she had asked another nurse to complete a discharge plan and mental health referral for him because one had not yet been done and she had no time to do it before she left.

#### **Nurse B**

74. Nurse B was working on the houseblocks and not the inpatient unit that day. He could not precisely recall the lunchtime handover meeting, but had a

recollection of an incident involving theft of tobacco from an elderly patient's cell and accepted that he might have briefed his colleagues about this.

75. He said that he did not have a conversation with the manager about discharging the man. He said that he had not spoken to him that day. He said that the manager did not ask him to complete a discharge plan or a mental health referral.
76. The nurse said that it would not have been appropriate for him to complete the discharge paperwork because he had not been involved in the process. He agreed that he might have been present on the inpatient unit at 3.45pm when the agency nurse made her entry in the clinical record, because he was not due to work on Houseblock 6 until 4.15pm but he said that the agency nurse had not asked him to complete a discharge plan.

### **After discharge**

77. On 8 November, a nurse at Birmingham made an entry in the man's electronic clinical record for healthcare staff at Hewell to read on their computer. She noted that his next depot injection was due on 13 November. A psychiatrist also made an entry the same day, her first Thursday clinic since he was sentenced. She checked his clinical record to confirm that he had transferred and added a note for Hewell staff that he needed a reduction in his oral risperidone. The same day, he telephoned his partner twice.
78. On 9 November, the man moved to a single cell A2-04 on Houseblock 2. That afternoon, Nurse B spoke to him at the medication hatch when he came to collect his prescription and he asked to see a member of the mental health team. The nurse completed a referral form on the computer for an appointment. He had to tick a number of boxes on the electronic form to indicate how serious the man's problems were. He recorded that there were minor concerns about self-harm or a suicide attempt, although he did not actually ask him whether he was having any suicidal thoughts or how severe these were if he was. The nurse scored him a total of 11 on the form, a score which meant that he would be reviewed within two weeks.
79. Nurse B did not ask the man the questions which the form required. He ticked the boxes he felt appropriate in order to secure a referral for him based on their interaction for two or three minutes at the hatch. The nurse told the investigator that he based the scores on the form on what he had heard about him at handover meetings and his appearance and mood when he spoke to him at the medication hatch. He wanted to ensure that he was reviewed but was busy issuing medication to other prisoners, so did not have time to interview him in order to gather sufficient evidence to complete the form accurately.
80. The inpatients manager told the investigator that Nurse B had admitted to her after the man died that he had forgotten to complete a mental health referral for him. The nurse told the investigator that he had never said this to her. The investigator asked if seeing the man at the medication hatch had

prompted him to remember that he was supposed to have done a discharge plan and mental health referral on 6 November. He said this was not the case. He said that he had never interacted with him before and that he had simply requested an appointment with the mental health team.

81. Five prisoners who lived on Houseblock 2 asked to speak to the investigator when he visited Hewell after the man's death. They described how he repeatedly asked the other men for tobacco. They said he did not talk much and seemed quiet and distant, keeping mostly to himself. He would stand outside his cell and shuffle from side to side. He seemed to be heavily medicated and had a vacant expression. He did not want to talk about his problems and he looked ill at ease. One of the men mentioned that he stuck out like a sore thumb. He did not discuss taking his life with any of the men who spoke to the investigator.
82. A Senior Officer (SO), one of the managers, told the investigator that the man was a quiet and private prisoner who did not appear to socialise much during his four days on Houseblock 2. He said that he had mentioned him to the inpatients manager, as he found his behaviour concerning. She reassured him that he would be seen by the mental health team.

### **Day of the incident**

83. The man's fortnightly depot injection was scheduled between 10.45am and 11.15am on 13 November but had not been administered before he died. The inpatients manager told the investigator that he had asked about his injection during the morning so he knew it was due to be given. It is not clear why this did not happen. He was locked in his cell for the majority of the morning and afternoon because he was not attending employment or education. He was unlocked to collect a meal between 11.30am and 12.15pm and then locked up again for the lunch period.
84. All of the cell doors on the wing were unlocked again at about 1.45pm. Those prisoners due to go to work or classes then left the houseblock. The rest of the men, including the man, were locked back into their cells at about 2.15pm. He was last seen alive at that time by Officer A when she locked him back in his cell. He had been leaning on the rails of the landing observing the wing and went into his cell and did not speak to her before she locked the door. She had not been on duty since 8 November and had not met him before. He was next due to be unlocked for dinner at 4.30pm.
85. At about 3.45pm, Officers A and B were in the A spur office on the second landing. Two prisoners were out of their cell and were talking on the stairs close to the man's cell. Prisoner A looked through the observation panel. He told the investigator that he was feeling nosy and wanted to see who was in the cell to talk to. It was dark in the cell but he saw the man slumped at the back. He thought that he might be intoxicated. He asked Prisoner B to take a look and then checked again. Both men then realised something was wrong and shouted to Officer A while she was walking from the A spur office to the centre office. She had to unlock one gate to reach the cell.

86. A Senior Officer (SO) was working in the centre office when a colleague alerted him to an incident he could see on A spur involving Officer A. He ran along the landing and saw the officer unlocking the man's cell door. Once the door was open, they saw him hanging at the back of the cell. He had tied one end of a length of torn bedsheet to the cell window and the other end around his neck. He was slumped in a seated position a few inches above the ground in front of the pipes. His arms were hanging loosely and his legs were splayed outwards towards the door. His face was blue.
87. The SO went into the cell first and used his cut down tool to remove the bedsheet from the window and then from the man's neck. He lowered him to the floor with an officer's help, with his head nearest the window. Officer A announced a code blue emergency using her radio at 3.47pm. She had some difficulty for a few seconds because of the amount of traffic going across the radio network. The SO told the investigator that after several attempts the message got through and control room staff directed emergency medical responders to the scene.
88. The SO tilted the man's head in order to open and maintain his airway and Officer A performed chest compressions. She had previously worked for the ambulance service and felt confident to do this. Officer B arrived in the cell. He used his radio to inform the control room that cardiopulmonary resuscitation (CPR) had started and that healthcare staff were definitely needed. He then took over from the SO supporting the head and neck. The SO went back onto the landing to manage the other prisoners and staff.
89. At 3.50pm, a healthcare assistant, two nurses and the healthcare manager attended the emergency. They told the prison officers to radio control room staff to call an ambulance. They took over chest compressions from Officer A, who left the cell. They cut off the man's T-shirt and attached a defibrillator to his chest. Throughout the incident the defibrillator repeatedly instructed staff not to administer a shock because there was no shockable heart rhythm detected.
90. Officer B brought the suction unit to the cell at 4.00pm, which the nurses used to remove vomit from the man's mouth. They gave him oxygen using a mask. Two paramedics reached the cell at 4.07pm and continued CPR. However, he could not be revived and a doctor pronounced death at 4.17pm. He did not leave a note in his cell.
91. Family liaison officers (FLOs) from Hewell went to the man's cousin's home, his nominated next of kin, at about 7.30pm. The cousin was not at home, but his wife said that the staff should inform the man's father, who lived nearby. Although he was the victim of his son's attack, she indicated that his father had forgiven him. The family liaison team visited the man's father to break the news. He asked them also to inform his son's mother.
92. Staff at Hewell asked two family liaison staff from HMP Woodhill to visit the man's mother because she lived in that area. His daughter was the only one

at home when they arrived late in the evening and she became distressed when she guessed what had happened. The two FLOs subsequently found her grandmother and broke the news.

93. The man's father and cousin agreed that the prison should treat his mother as the principal family contact. The next day, staff at Hewell telephoned the man's mother to offer to contribute to the cost of his funeral and arranged for her to visit his brother in a different prison to break the news. His brother was supported by staff. Staff at Hewell had initially had difficulty locating his partner but they broke the news to her by telephone later that day.
94. A consultant forensic psychiatrist from the Raeside clinic, who holds a weekly clinic at Hewell, had been due to review the man at midday on 15 November.
95. The funeral was held on Saturday 17 November.

## **ISSUES**

### **The man's mood at HMP Birmingham**

96. The man's behaviour was very chaotic when he first arrived at Birmingham in February, but his mental health improved after two admissions to the healthcare centre and some changes to his medication. The man's former keyworker told the investigator that his mental health had already stabilised when she began seeing him during the early summer. He responded well to his medication and never presented as a concern for the rest of his time there. He was polite and cooperative and engaged well.
97. The man was anxious about harming anybody again after his assault on his father. His keyworker said that he was fearful but never negative about the future. She told the investigator that his anxiety about his court case was nothing exceptional, just an entirely understandable reaction in the circumstances. He was looking forward to moving to a secure hospital because he wanted a proper opportunity to get better. She found his death particularly shocking because she thought that he would have been pleased with his hospital order and the opportunity it offered.
98. A psychiatrist told the investigator that the man's mood was consistent between August and early November, when she was involved in his care. He was anxious about relapsing, the risk he might present to others, the outcome of his court case and the date of his hospital admission. However, he seemed calm and relaxed whenever she reviewed him. He had some residual psychotic symptoms but his mental illness was mostly well controlled.

### **Failure of medical hold and transfer to Hewell**

99. In September, the man's keyworker placed him on medical hold while psychiatric reports were prepared and the process of moving him to a secure hospital was completed. This meant that he was not supposed to transfer from Birmingham. A high priority reminder to this effect was placed on the front page of his clinical record.
100. The man transferred to Hewell on 2 November for two reasons. Firstly, his court case was switched at the last minute from one Crown Court to another, which routinely returns prisoners to Hewell. He could still have been directed back to Birmingham after his court appearance if a note about the medical hold instruction had been written on the PER which accompanied him. However, the nurse who checked the clinical record the night before and completed the health risks section of the PER did not do this.
101. The man's keyworker told the investigator that she was not that concerned that he had transferred to another prison, because Hewell's in-reach team were perfectly able to take over his care following a handover. She said that medical hold is a practice that she rarely sees at Birmingham and that she and the psychiatrist were confident that he was stable on his medication when he transferred.

102. Nevertheless, it is regrettable that the medical hold instruction failed. The man's continuity of care was unnecessarily disrupted. As his keyworker felt it was necessary to place the alert on his clinical record, it should have been correctly marked on the PER. We make the following recommendation:

**The Head of Healthcare at Birmingham should ensure that any medical hold instruction on a patient's clinical record is marked on his Person Escort Record when he makes a court appearance.**

### **Admission to the inpatient unit**

103. When the man transferred to Hewell, his risk was raised by a number of factors:

- his court appearance and the imposition of the hospital order
- his mental health
- the fact that he had assaulted a close family member
- his transfer from Birmingham and loss of continuity of care

104. A doctor agreed to admit the man to the inpatient unit at the insistence of the duty governor. The inpatients manager felt strongly in her interview that the duty governor had admitted him herself and should not have done so. We accept that the duty governor instructed the doctor, who did not think that there was a clinical reason for him to be admitted. However, the admission was ultimately under the doctor's name. While we were told there were a number of prisoners awaiting transfer to secure hospital living on houseblocks at Hewell, we think the doctor's admission of the man for observation was a sensible precaution in view of his risk factors.

105. The investigation indicated a lack of clarity over who makes admissions to the inpatient unit and what should be done for newly arrived prisoners subject to a hospital order. There also seems to be disquiet about the influence that prison managers can have over decisions to admit prisoners to healthcare. We believe that these issues should be resolved and make the following recommendations:

**The Governor of Hewell and the Head of Healthcare should ensure that there is a clear process for admitting prisoners to the inpatient unit, based on clinical need.**

**The Governor of Hewell and the Head of Healthcare should ensure that there is a clear and consistent process for managing of prisoners subject to hospital orders.**

### **Assessment of risk**

106. Staff did not consider that the man should be monitored as a risk of self-harm at Hewell. While there were a number of risk factors, on balance we consider this was not an unreasonable conclusion. Although his risk factors rightly

caused the duty governor concern, he did not indicate that he had any suicidal thoughts and he had been making good progress at Birmingham. He was stable on his medication and did not appear depressed or anxious during the reception process. It was a sufficiently cautious step to locate him in the inpatient unit for monitoring, although we are concerned, as discussed below, that possible substance use problems, which could have increased his risk, were not identified.

### **Integrated Drug Treatment System (IDTS)**

107. The officer who conducted the man's first night interview on 2 November noted 'detox from Subutex' but no further information was provided. It is not clear from this entry whether he reported he was withdrawing from subutex dependency and needed support. Whatever the case, no referral to drug services was made as a result, or any other action taken.
108. Three days later, on 5 November, the man spoke to the manager of the IDTS service and asked to see an IDTS nurse about detoxification. He did not elaborate further. The manager said that she asked a nurse to assess him the same day, but this did not happen and nobody else from the IDTS team assessed him subsequently. The next day he told a worker from the CARAT service, which provides support to substance users as opposed to clinical interventions, that he did not wish to engage with them.
109. During interview, the IDTS manager agreed that the failure to assess the man occurred because nothing was written down at the time. Both his request and hers were verbal, and the referral seems to have been overlooked. It is not clear whether he had a substance misuse problem at the time. There is no indication from his clinical record at Birmingham that he was using illicit medication, nor is there any information that he was suspected of doing so.
110. The IDTS manager told the investigator that there was some illicit trading of tramadol and subutex among prisoners on the inpatient unit in November 2012. She had thought it possible that the man had been exposed to this and was feeling vulnerable. However, he had identified a problem on his first night which was not followed up. He had a history of substance misuse and should have been reviewed by an IDTS nurse after his first night assessment as well as when he asked her about detoxification on 5 November. Without an assessment we do not know whether he was suffering from withdrawal symptoms or whether he needed treatment. We make the following recommendation:

**The Governor of Hewell and the Head of Healthcare should ensure that all prisoners who indicate they have any substance misuse treatment needs are referred to the IDTS team and the referrals are properly recorded and actioned.**

## **Discharge from the inpatient unit on 6 November**

111. The man was discharged from the inpatient unit without:
- A discharge plan
  - A recorded discussion among healthcare colleagues or a recorded decision by a senior member of staff
  - A referral to the mental health team (MHT) to ensure that he was monitored once he was located on a houseblock. This would also have ensured that he was allocated a keyworker because all prisoners subject to hospital orders need to be on the MHT's caseload once they leave the inpatient unit.
112. There was one brief entry from Nurse A in the clinical record about the man's discharge. The investigator asked to see the wing observation book from the inpatient unit but the book covering 6 November is missing and staff have been unable to locate it, which is a concern.
113. The clinical development lead for mental health and the senior nurse in charge on the inpatient unit on 6 November discharged the man. She explained during interview that he was happy to be discharged. He had coped well in the inpatient unit, was taking his medication and did not require 24 hour healthcare.
114. She told the investigator that the decision to discharge the man was taken jointly with Nurses A and B. She was certain that she then asked one of them to complete a discharge plan and referral to the mental health team. She said that both nurses had discharged patients before and that they were suitably experienced to complete this task. She explained that she is not responsible for completing discharge plans. She was satisfied that she had performed her role correctly on 6 November.
115. She also insisted that, a few days after the man died, Nurse B spoke to her in the office on Houseblock 4 and admitted to her that he had forgotten to complete the man's discharge plan. During interview, Nurse B denied that he ever said this.
116. Both nurses both deny that they were involved in the decision to discharge the man, or that they were asked by the inpatients manager to complete a discharge plan or mental health referral.
117. Nurse A was certain that the inpatients manager made the decision to discharge the man alone. Later in the day, she said she noticed that nothing about his discharge had been written in the clinical record, so she made an entry as her shift finished. She told the investigator that she asked Nurse B to complete the discharge plan which would indicate that she accepted that either she or he should have completed it. Nurse B denies that Nurse A asked him to do this. Whether or not the inpatients manager discharged the man alone or with the input of other colleagues, she was the senior staff

member present and was therefore ultimately responsible for ensuring it was done.

118. Our interviews revealed confusion about the roles and responsibilities of healthcare staff. The inpatients manager had responsibility for the inpatient unit at the time (although this has since changed). However, she told the investigator that she was not accountable for clinical decisions made by other nurses and was not responsible for managerial decisions, which she maintained was the remit of the Head of Healthcare. She explained that she was responsible for overall service delivery on the inpatient unit and that this involved acting in an advisory capacity to more junior staff. Although she was in overall charge, she was not based on the inpatient unit. She said that she could not take sole responsibility for discharging the man because she was not involved in his round-the-clock clinical care. She described her role on 6 November as coordinating a collective decision based on the clinical opinion of the nurses working with him. Her view of her role seems at odds with the relevant part of her job description, introduced in April 2012, which states:

‘To be responsible for the day to day care of patients admitted to the inpatient unit, for mental health reasons...’

119. The inpatients manager told the investigator that she had been under-staffed on the inpatient unit and that in reality her job description was far too broad for her to be able to accomplish. She said that she could not be everywhere at once. She does not agree that the job description accurately reflected her role. She described day to day life on the inpatient unit at the time as ‘firefighting’ and said that it was a failing unit that did not offer dignity or decency to patients.
120. The Head of Healthcare told the investigator that the inpatients manager had a senior nursing role. He said that the most senior member of staff present during a discharge was responsible for that decision and considered that she should have made a brief entry in the clinical record to explain the reason for discharge. He said he was disappointed at her reluctance to take responsibility for the discharge process and any associated failings.
121. He told the investigator that the senior nurse in charge of the inpatient unit can discharge a patient in consultation with colleagues. They do not have to wait for the opinion of a GP or psychiatrist. He stated that every patient should have a discharge plan completed as a minimum requirement before they leave the unit.
122. However, he also accepted that Hewell does not have a written policy outlining who is responsible for discharging patients from the inpatient unit and what procedures must be followed. This might explain the confusion surrounding the man’s discharge. The Deputy Governor has issued the temporary guidance since the man’s death to help ensure appropriate discharge arrangements, including a re-integration plan agreed with residential staff.

123. The man had no care plan and had not been allocated a mental health keyworker when he died. His depot injection was scheduled for 13 November and he was due to see a doctor on 15 November. He was located on two different houseblocks after he left healthcare. This meant that staff on Houseblock 2 were not familiar with his circumstances. A SO told the investigator that he was unaware that he was the subject of a hospital order.
124. We do not consider that the decision to discharge the man to a general residential unit was in itself unreasonable. He had been living in these circumstances at Birmingham for several months. However, no plan was recorded about how to monitor and care for him until he moved to hospital and there was no evidence to support his discharge.
125. It is important that prisoners are discharged from the inpatient unit with appropriate consideration and that any ongoing mental health needs are addressed in a care plan. These decisions should be properly recorded. We make the following recommendation:

**The Head of Healthcare at Hewell should implement a clear discharge policy for the inpatient unit and ensure that staff make full entries in the clinical record about decision making, assessments and care planning.**

126. The clinical reviewer comments in her clinical review:

‘Throughout all of the interviews there was definite evidence of an unhealthy culture within the healthcare centre that needs to be rectified to ensure that the prison population receives the highest standards of care delivered by an effective and supportive healthcare team.

‘In summary it appears that the healthcare centre is run on vague processes, systems, accountabilities and responsibilities.’

127. Our investigation has revealed severe problems in the relationships in healthcare team at Hewell. Staff did not support each other’s versions of events during interview. This is bound to have had an impact on morale and staff relations. Our interviews demonstrated that staff do not understand their roles and responsibilities. The lack of written policy meant that the man’s discharge was poorly performed and documented. Our initial feedback has already resulted in the Head of Healthcare and the Governor agreeing an Inpatient Development Plan to make sure that the inpatient unit functions properly. We understand that new staff are being recruited, including a permanent manager for the inpatient unit.
128. She has recommended, in her clinical review, that the NHS Trust support the Head of Healthcare in implementing the recommendations from this report. We do not repeat the recommendation here but hope that they can work together to ensure that procedures in the healthcare unit at Hewell are robust and that all staff in the unit understand their own roles and those of their colleagues.

## **Mental health referral on 9 November**

129. On 9 November, the man spoke to Nurse B at the medication hatch. He asked to be reviewed by the MHT. To initiate this process, the nurse completed a TAG referral form. This form asks a number of questions and staff must tick the appropriate boxes to indicate the degree of concern about the prisoner. The member of staff needs to carry out a short interview with the prisoner to briefly check his thoughts and feelings in order to refer him with appropriate urgency.
130. Nurse B recorded minor concerns about suicide and self-harm on the TAG form. However, he did not actually ask the man about any suicidal thoughts he might be having. The nurse said he had only had a very brief chat with him at the hatch to confirm that he would refer him. This interaction lasted a couple of minutes and they did not sit down in a private room to go through the referral. The nurse completed the form in such a way as to ensure that he would be reviewed within two weeks. The boxes he ticked did not necessarily accurately reflect the man's mood.
131. We are concerned that the nurse did not conduct a sufficiently detailed interview to gather evidence to assess accurately how urgently the man needed to be seen. We make the following recommendation:

**The Head of Healthcare at Hewell should ensure that the mental health referral process is performed appropriately by all staff.**

## RECOMMENDATIONS

### **For the Head of Healthcare at Birmingham:**

1. The Head of Healthcare at Birmingham should ensure that any medical hold instruction on a patient's clinical record is marked on his Person Escort Record when he makes a court appearance.

The Head of Healthcare at Birmingham accepted the recommendation and provided the following response:

'There is a clear process for placing prisoners on medical hold which requires staff to update the prison Observation, Classification and Allocation department for them to note Person Escort Record forms with medical hold information as necessary.'

### **For the Governor of Hewell and the Head of Healthcare:**

2. The Governor of Hewell and the Head of Healthcare should ensure that there is a clear process for admitting prisoners to the inpatient unit, based on clinical need.

The Governor and the Head of Healthcare at Hewell accepted the recommendation and provided the following response:

'By 31 July we will develop and circulate an admission and discharge policy to all healthcare and relevant prison staff for comment and then amendment.'

'The policy will indicate a stepped process with all stages clearly outlined and documented in the patient record.'

3. The Governor of Hewell and the Head of Healthcare should ensure that there is a clear and consistent process for managing of prisoners subject to hospital orders.

The Governor and the Head of Healthcare at Hewell accepted the recommendation and provided the following response:

'[By 31 August we will] develop a protocol for the local management of all prisoners on hospital orders.'

'This [protocol will] include all prisoners being discussed at the weekly MDT (multi-disciplinary team) meetings chaired by a senior mental health nurse or a healthcare manager and attended by the consultant psychiatrist and other healthcare and prison professionals.'

4. The Governor of Hewell and the Head of Healthcare should ensure that all prisoners who indicate they have any substance misuse treatment

needs are referred to the IDTS team and the referrals are properly recorded and actioned.

The Governor and the Head of Healthcare at Hewell accepted the recommendation and provided the following response:

'[By 31 August we will] complete a review of the IDTS referral process and update / amend the referral process outlined in the substance misuse policy as necessary.'

#### **For the Head of Healthcare at Hewell**

5. The Head of Healthcare at Hewell should implement a clear discharge policy for the inpatient unit and ensure that staff make full entries in the clinical record about decision making, assessments and care planning.

The Head of Healthcare at Hewell accepted the recommendation and provided the following response:

'By 31 July we will develop and circulate an admission and discharge policy to all healthcare and relevant prison staff for comment and then amendment.

'There is currently a protocol already in place for the joint working around discharges from the inpatient unit which involves joint decisions being made between a healthcare manager and a prison governor about the safe discharge of a prisoner back to a houseblock, including follow up support and clear communication with the houseblock the prisoner is going to.

'All staff to be reminded to make full and accurate entries in the clinical record with regard to decisions made about an individual's care.

'Assurance checks by the Head of Healthcare and the Head of Residential Safety are to be included in the policy but are already being carried out.'

6. The Head of Healthcare at Hewell should ensure that the mental health referral process is performed appropriately by all staff.

The Head of Healthcare at Hewell accepted the recommendation and provided the following response:

'[By 30 September we will] develop and implement a policy detailing the mental health referral process including fast track processes for patients received into the prison already under the care of forensic in reach mental health services or those with a hospital order awaiting transfer to a secure unit.

'The policy will include management checks to ensure the referral process is being correctly applied for all patients.'