submitted to Professor Alan Wilson's committee of inquiry will prove helpful and acceptable.

Ruben makes the important point that doctors will have to be taught to expect complaints as a matter of course and how to deal with them. We need above all a more sympathetic and understanding complaints procedure that will offer immediate and far greater help and support.

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1 Ruben LA. Complaints procedures. *BMJ* 1993;307:622. (4 September.)

HIV and insurance

EDITOR,—Despite the assurances of the insurance industry anxiety continues to be expressed about the implications for insurance of having been tested for HIV antibody.[1-3] British Aerospace has had a large workforce in Saudi Arabia for many years. Since 1986 it has had to comply with the requirement that all people applying for a Saudi Arabian visa must have been shown to be negative for HIV antibody.

During pretest counselling, employees have been informed that virtually all application forms for life or sickness insurance include questions about HIV testing. They have been told that if the result of the test is positive, obtaining such insurance will be virtually impossible, but if the result is negative a wise response is to state that they were tested for the purpose of obtaining a visa for Saudi Arabia and that the result was negative. They have been asked to report to us any difficulties they may have with insurance companies when the sole reason would be their having been tested for HIV antibody. To the end of June this year we had tested over 4000 men aged 20-55. We know of none whose insurance has been prejudiced solely by such testing and have received fewer than 20 inquiries. These have either been from the applicants requesting copies of their reports or from insurance companies asking for confirmation of the purpose of the HIV testing.

HIV testing for reasons not associated with risk behaviour does not seem to have resulted in difficulties in obtaining insurance for this large group of men.

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1 Goold JE. HIV and insurance. *BMJ* 1993;307:204. (17 July.)
2 Searle GF. HIV and insurance. *BMJ* 1993;307:204. (17 July.)
3 Reynolds MA. HIV and insurance. *BMJ* 1993;307:204-5. (17 July.)

Talc is not magnesium trisilicate

EDITOR,—In their letter A D Hingorani and R W Ainsworth imply that talc is magnesium trisilicate. It is not. The approximate formula for talc is $Mg_6\ (Si_2O_5)_4(OH)_4$ and for magnesium trisilicate $2MgO,3SiO_2$.[2]

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1 Hingorani AD, Ainsworth RW. Pulmonary microembolisation and temazepam. *BMJ* 1993;307:623-4. (4 September.)
2 *Martindale. The extra pharmacopoeia.* 30th ed. London: Pharmaceutical Press, 1993.

Care of suicidal prisoners

Use of unfurnished rooms is exceptional . . .

EDITOR,—It is a pity that the authors of the editorial on seclusion in prison strip cells did not consult with me to improve its accuracy.[1] A protective room is a purpose designed and purpose built hospital room certified as providing a safe environment for a patient who is seriously at risk of hurting himself or herself or others. An unfurnished room is essentially an ordinary hospital room that can be used normally but from which the fittings and furniture can be removed to reduce the risk of the patient injuring himself or herself whether accidentally or intentionally.

I do not expect that a patient at risk of suicide will be nursed in a protective or unfurnished room, except in exceptional circumstances identified by the responsible doctor. The case in Bristol mentioned in the editorial was an exceptional case.

I have been monitoring the use of protective and unfurnished rooms since 1991 while at the same time encouraging improved care for patients in health care facilities. In March last year unfurnished rooms were being used 140-150 times each week across the 130 prison establishments. In June this year the figure had dropped to 40-50 times in any one week—that is, a reduction in the use of these facilities of 72% in just over a year. The Health Care Service for Prisoners is not complacent, but transformed practice is indeed following closely behind transformed policy.

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1 Liebling A, Hall P. Seclusion in prison strip cells. *BMJ* 1993;307:399-400. (14 August.)

. . . and a last resort

EDITOR,—Bristol prison's Board of Visitors in 1991 rightly drew attention to the case of the young man whose suicidal ideation was so severe that he attempted to kill himself eight times and thus had to be managed in an unfurnished room for 28 days.[1]

Bristol prison's health care services for prisoners in conjunction with local forensic psychiatric services worked slavishly to transfer this man to the NHS. He went from Ashworth Hospital back to prison after nine days because he was considered not to be mentally ill. He remained a situational suicide risk in prison. Finally, the court accepted that he be discharged under a probation order. He has made a good recovery and is grateful to be alive.

At that time there was no alternative to manage him other than in the unfurnished room. No doctor would use an unfurnished room for the management of a suicidal patient if he or she had an alternative.

Bristol prison followed the example of Swansea prison, and we have a listener scheme in place whereby inmates trained by the Samaritans support their peers. Bristol prison's health care centre accommodates a listener overnight and during the day listeners are available for all suicidal inmates. Additionally, by the end of 1993 a special suite incorporating a comfortable bedroom and sitting area will accommodate the suicidal inmate with a listener in support for 24 hours continuously as required.

The senior management of Bristol prison has plans to convert the health care centre area to incorporate a ward to nurse suicidal patients. It is investing in the progression of its nursing services over the next few years so that it can build up the necessary resources to staff this ward on a 24 hour basis. This strategy, in the view of the senior medical officer, governor, and the chairman of the board of visitors, will finally deliver the range of complex and resource intensive services required to provide the realistic rather than aspirational alternative to unfurnished rooms required by the prison doctor to manage the suicidal patient.

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1 Liebling A, Hall P. Seclusion in prison strip cells. *BMJ* 1993;307:399-400. (14 August.)

Deliberate self harm is underreported

EDITOR,—Alison Liebling and Peter Hall are right to question the figure of 746 recorded episodes of self harm by prison inmates during 1991-2.[1] This is probably the number of form 220s completed during that period; these forms should be submitted after all attempted suicides but in practice are used only after "genuine" attempts or those associated with clinical depression.

For one year from 1 April 1990 I recorded episodes of deliberate self harm. Twenty seven inmates made 29 attempts. Of these, 18 involved wrist lacerations, eight were attempts at hanging or strangling, and one involved wrist lacerations and an attempt at hanging, and there were two others. Fifteen inmates spent time in an unfurnished room, which more closely resembles a "strip cell" than the editorial implies. Five were transferred to Hull prison, where there are full time medical staff, and the rest were managed in the ward of the health care centre. Extrapolating a rate of slightly over one episode of deliberate self harm a fortnight in an institution with about 300 inmates to the prison population as a whole gives some idea of the true extent of the problem.

Though I do not condone the use of strip cells, some explanation of their use is appropriate. In an institution with a part time medical officer the hospital officers, who are prison officers with some basic training in nursing, usually place a prisoner who threatens to commit or has committed self harm in a strip cell pending a medical opinion. This is, as Liebling and Hall suggest, a tactic to minimise risk.

Unfortunately, strip cells are also used for punishment because of an attempt to apply a medical model to certain forms of behaviour. Apparently distressed prisoners are submitted to "trial by medical officer." If judged to be depressed they are regarded as having a medical problem and given minimal treatment along the usual lines. If, however, they are judged to have a personality problem, and thus not to have a medical problem, they are by implication being manipulative. Hence they are punished by being put in a strip cell until they are more compliant. The diagnosis of a personality problem in a distressed inmate who does not have a formal psychiatric illness may prove disastrous in prisons starved of resources.

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1 Liebling A, Hall P. Seclusion in prison strip cells. *BMJ* 1993;307:399-400. (14 August.)

Correction

Serum screening for Down's syndrome

An editorial error occurred in this letter by Richard Keatinge and Cerilan Rogers (21 August, pp 501-2). The final sentence of the third paragraph should begin: "Over 40% of all women whose fetus has Down's syndrome are incorrectly given negative results on screening, . . ."