Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Ms Diana Grant, a prisoner at HMP Bronzefield, on 20 November 2021

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Ms Diana Grant died on 20 November 2021 at HMP Bronzefield. The preliminary post-mortem report found that her death was caused by an upper airway obstruction (a pair of women's underwear was removed from her airway during the post-mortem examination). She was 42 years old. I offer my condolences to Ms Grant's family and friends.

Ms Grant had been at Bronzefield for only one day when she died. She arrived on 19 November with a suicide and self-harm warning form and a request that staff assess her for placement in the prison's healthcare unit. However, reception staff failed to start suicide and self-harm prevention procedures (known as ACCT) and she was put in a cell on a standard houseblock. She was also not seen by a prison GP as she should have been.

I am extremely concerned that despite Ms Grant arriving at Bronzefield with clear warnings about her high risk of suicide and poor mental state, staff failed to put in place any measures to try to protect her. The Governor needs to ensure that reception screening procedures are improved so that prisoners who are at risk of suicide and self-harm are promptly identified and supported.

It is not within my remit to consider the decision that led to Ms Grant, a very vulnerable Black woman who was acutely mentally ill, being sent to prison. However, I am troubled by the tragic circumstances of Ms Grant's death, given she took her life just a day after arriving in prison.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman **May 2023**

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Summary

Events

1. On 19 November 2021, Ms Diana Grant (formerly Chantelle Grant) was remanded in prison custody, charged with attempted murder and assault, and sent to HMP Bronzefield. It was her first time in prison.

2. Ms Grant, who had schizophrenia, had tried to stab her mother multiple times. The court's Liaison and Diversion (L&D) Team (who assess individuals with mental health issues, learning difficulties or other vulnerabilities) prepared a report and emailed it to the mental health in reach team at Bronzefield. They asked staff to assess her for placement in the prison's healthcare unit and said that they had completed a suicide and self-harm warning (SASH) form. The SASH form said that Ms Grant was acutely psychotic and at high risk of suicide and self-harm. The operational manager of Bronzefield's healthcare unit arranged for a room to be prepared for Ms Grant and notified the relevant staff.

3. When Ms Grant arrived at Bronzefield, the senior prison custody officer in reception saw the SASH form and he said he passed it to the interviewing officer. She said she did not see it and nor did the reception nurse. No one started suicide and self-harm monitoring (known as ACCT).

4. The reception nurse said he saw the L&D report but did not read the email about locating Ms Grant in the healthcare unit. He assessed that Ms Grant should be located on a standard houseblock.

5. The reception GP did not assess Ms Grant. Another GP was supposed to assess her by telephone the next morning, but he did not know her location because it was not on her medical record. Ms Grant's location was on her prison record, but the GP did not access it or ask anyone to access it for him.

6. That night, prisoners heard Ms Grant shouting about the devil. However, she was quiet later in the night. The next day, she ran out of her cell when staff opened her door to give her hot water. She initially refused to go back to her cell but then staff managed to walk her back. She was shouting and pushing at the window but then seemed to calm down again.

7. At around 9.05pm, an officer saw Ms Grant on the floor of her cell, half underneath her bed. He banged on the door, but she did not respond. He called a nurse on the wing to take a look. The nurse asked to go into the cell and the officer sought permission from the night orderly officer (the senior officer in charge at night) who granted it. The nurse found that Ms Grant was not breathing and at 9.14pm, called a medical emergency code blue. Staff attempted resuscitation before paramedics arrived. They declared Ms Grant dead at 9.50pm.

8. The final post-mortem report concluded that Ms Grant died from an upper airway obstruction which caused cardiorespiratory collapse. A pair of women's underwear was removed from her airway during the post-mortem examination.

Findings

9. Neither the interviewing officer in reception nor the reception nurse saw the SASH form. It is unclear what happened to it. This was a crucial document and should have prompted reception staff to start ACCT monitoring. Even without the SASH form, reception staff should have identified Ms Grant's risk factors for suicide and self-harm and started ACCT monitoring. Staff placed too much emphasis on Ms Grant's apparently calm presentation rather than considering her risk factors.

10. The reception nurse ignored the information about locating Ms Grant in the prison's healthcare unit. Again, he focused on Ms Grant's presentation at that time, rather than the L&D assessment.

11. Neither of the GPs made adequate attempts to assess Ms Grant and the reception GP failed to make any record of why she had not seen Ms Grant.

12. There was a delay in going into Ms Grant's cell while the officer sought permission from the night orderly officer. This was unnecessary in the circumstances.

Recommendations

- The Director and the Head of Healthcare should ensure that reception staff:
  - are aware of the risk factors that might increase a prisoner's risk of suicide and self-harm;
  - consider all relevant documentation that arrives with a prisoner, in particular the PER (and SASH form, if completed);
  - base their assessment on a prisoner's known risk factors and not on their presentation;
  - record the risk factors they have identified and their reasoning for not starting ACCT procedures; and
  - retain the completed paperwork and store it securely.
- The Director should share this report with SPCO A, PCO A and PCO B and arrange for a senior manager to discuss the Ombudsman's findings with them.
- The Head of Healthcare should share this report with Nurse A and discuss the Ombudsman's findings with him.
- The Head of Healthcare should ensure that when senior staff indicate that a new prisoner should be located in the healthcare unit, the reception nurse is made aware and consults with senior staff if they propose to locate the prisoner on a standard houseblock.
- The Head of Healthcare should ensure that:
  - newly arrived prisoners are seen by a GP if they are referred for a GP assessment; and

- if a prisoner is not seen, the GP records the reason in the prisoner's medical record and arranges for them to be seen as soon as possible.

- The Director should ensure that staff understand that they can enter cells at night in medical emergencies without the permission of the night orderly officer in line with PSI 24/2011.

The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Bronzefield informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

14. The investigator obtained copies of relevant extracts from Ms Grant's prison and medical records.

15. The investigator interviewed 16 members of staff during February and March 2022. NHS England commissioned a clinical reviewer to review Ms Grant's clinical care at the prison. The investigator and clinical reviewer jointly interviewed healthcare staff and some custodial staff.

16. We informed HM Coroner for Surrey of the investigation. The coroner gave us the preliminary post-mortem report. We have sent him a copy of this report.

17. The Ombudsman's family liaison officer contacted the solicitor acting on behalf of Ms Grant's next of kin to explain the investigation and ask if there were any issues they wanted us to consider. The solicitor sent us questions about Ms Grant's time at Bronzefield which are covered in this report.

18. Ms Grant's family received a copy of the initial report. The solicitor representing them wrote to us seeking clarification on certain matters before he forwarded them the report, and we answered by way of separate correspondence. We did not receive any further correspondence about any factual inaccuracies.

19. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Bronzefield

20. HMP Bronzefield holds adult and young offender women prisoners. It has four houseblocks, plus a healthcare unit providing 24-hour care for up to 17 prisoners.

21. The prison is operated by Sodexo Justice Services (SJS) who provide primary healthcare including mental health and integrated substance misuse services. Secondary mental health care is provided through the mental health inreach team by Central Northwest London NHS Foundation Trust (CNWL). General practitioners are employed through a contract with Med-Co Secure Healthcare Services Ltd.

HM Inspectorate of Prisons

22. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Bronzefield in January and February 2022. Inspectors found a prison working hard to care for many women with serious mental health difficulties. They noted that many of these women did not belong in prison and had been placed there as a place of safety because of inadequate service provision (86 women in the preceding two years). They also found that women arriving at the prison received good individual support and interviews were appropriately focused on safety.

23. Recorded rates of self-harm were 72% higher than at the previous inspection, but a small number of women accounted for almost two thirds of all incidents.

Independent Monitoring Board

24. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. Their latest annual report for the year to 31 July 2021 noted that the number of self-harm incidents had escalated during the reporting year to an average of 220 per month (from 175). They also noted an improvement in the transfer of severely mentally unwell prisoners to secure inpatient mental health hospitals. There was an increase in missed GP and nurse appointments with both rates doubling.

Previous deaths at HMP Bronzefield

25. There were no deaths at Bronzefield in the two years before Ms Grant's death.

Assessment, Care in Custody and Teamwork

26. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be

carried out at irregular intervals to prevent the prisoner anticipating when they will occur. Regular multidisciplinary review meetings involving the prisoner should be held.

27. As part of the process, a caremap (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, Management of prisons at risk of harm to self, to others and from others (Safer Custody).

Key Events

28. On 19 November 2021, Ms Diana Grant (formerly Chantelle Grant) was remanded in prison custody, charged with attempted murder and assault, and sent to HMP Bronzefield. It was her first time in prison.

29. Two days before, Ms Grant, who had schizophrenia, had tried to stab her mother multiple times. Afterwards, witnesses saw Ms Grant crawling naked down the road. When she was arrested, she told police she had been hearing voices for two or three days, even though she was on medication.

30. At 12.30pm on 19 November, a member of the Willesden Magistrates' Court Liaison and Diversion (L&D) Team emailed the mental health inreach team at Bronzefield about Ms Grant. (L&D services, run by the NHS, identify and assess individuals in the criminal justice system who have mental health issues, learning disabilities or other vulnerabilities.) She attached an L&D report on Ms Grant and said that a suicide and self-harm warning (SASH) form had been completed and placed in Ms Grant's Person Escort Record (PER, a form that accompanies all prisoners when they move between police custody, court and prisons, which sets out the risks they pose). She also asked for staff to assess Ms Grant for placement in the prison's healthcare unit.

31. The Inreach consultant forensic psychiatrist received the email and at 1.15pm, forwarded it to the operational Head of the prison's healthcare unit. The psychiatrist's covering message said that Ms Grant 'might need to come into healthcare'.

32. At 1.41pm, the operational Head forwarded the email to several people. Her covering email message said that they were looking to make space in the healthcare unit for Ms Grant. She also spoke to a Senior Prison Custody Officer (SPCO) and the duty manager and told them that room 12 was being prepared for Ms Grant.

33. A nurse saw the email at approximately 3.00pm in the afternoon. She phoned Nurse A, the reception nurse, and told him about the email, including the plan to locate Ms Grant in the healthcare unit. She did this because she knew from experience that clinical information did not always reach the nurse completing the reception health screen.

HMP Bronzefield

34. Ms Grant arrived at Bronzefield shortly before 6.00pm. SPCO A spoke to her when she arrived and described her as quiet and timid. He reviewed the Person Escort Record and found a loose SASH form. It said that Ms Grant was presenting as acutely psychotic, had a history of suicidal thoughts and was assessed as at high risk of suicide and self-harm. It recommended an ACCT assessment and an assessment for placement in the prison's healthcare unit. It also said that an urgent referral had been made to the prison's mental health inreach team. The SPCO said he passed the PER and SASH form to Prison Custody Officer (PCO) A, the interviewing officer in reception.

35. PCO A noted in Ms Grant's electronic prison record (NOMIS), 'First time in prison. Pleasant and polite during interview'. She told the investigator that she did not see the SASH form. Neither she nor the SPCO started ACCT procedures.

36. PCO B, a member of the safer custody team, also saw Ms Grant in reception. She noted it was her first time in prison, but she appeared calm and had no thoughts or history of self-harm. She told the investigator that she did not see any paperwork. She did not start ACCT procedures.

37. Nurse A carried out Ms Grant's reception health screen. He saw the PER but not the SASH form. He was aware from the telephone call from his colleague that an L&D assessment had been done in court, that he would need to assess Ms Grant and decide on the best place to locate her and refer her to the mental health team. He read the L&D report but not the covering email about the SASH form and the plans to locate Ms Grant in the healthcare unit. He noted that Ms Grant was schizophrenic and that she had been charged with the attempted murder of her mother.

38. Nurse A described Ms Grant as distant, guarded, pensive and preoccupied. However, she said she had no current thoughts of suicide or self-harm. He did not start ACCT procedures.

39. Nurse A recorded that Ms Grant needed an urgent assessment by a psychiatrist and a nurse. He emailed the mental health team later that evening and made a referral for her to see a psychiatrist. He also referred her to the GP, who was still in reception. He expected the GP to see her that evening. He recorded that Ms Grant should be located in Houseblock 2. When interviewed, he said he could see no clinical reason why Ms Grant needed to go to the healthcare unit as she had no physical health needs, no substance misuse issues and no psychotic symptoms at that time.

40. A prison GP in Reception that evening told the investigator that she recalled speaking to Nurse A and that he told her Ms Grant needed a mental health review. She said she was unaware of the L&D report and the psychiatrist's email. She said that she had called Ms Grant in to see her, but she had already been taken down to the houseblock and she thought she was going to be brought back to see her. She said she added Ms Grant's name to the GP ledger so a doctor could see her the following morning. She did not make a record of her discussion with Nurse A or record why she had not seen her.

41. Once the reception process was completed, a PCO took Ms Grant to Houseblock 1. It is unclear who decided she should be taken to Houseblock 1 instead of Houseblock 2 (Houseblock 1 had a nurse presence which Houseblock 2 did not).

42. Staff checked on Ms Grant six times during the night (in line with first night checks). Although an officer noted Ms Grant was shouting and woke people up at around 10.10pm, by the time a PCO came on shift an hour or so later, Ms Grant was quiet. She remained quiet for the rest of the night.

20 November

43. At 10.41am, a PCO noted on Ms Grant's electronic prison record (NOMIS) that Ms Grant had asked other prisoners if they had heard the devil screaming in the night and that she would refer her to the mental health team.

44. At 10.50am, PCO C noted on NOMIS that Ms Grant was behaving oddly. She would freeze with an empty look for a few moments before talking normally again but without maintaining eye contact. Other prisoners had reported that Ms Grant was shouting during the night and talking in a distorted voice about the devil. The PCO recorded that she had asked Ms Grant if she had any intentions of self-harm, but she said she did not. She noted that the spur SPCO was going to make a mental health referral.

45. PCO C recorded that Ms Grant's room was in good order, but her phone was missing, and she said she was not given a PIN at reception. The SPCO provided a new phone and, later on, the PCO looked into the PIN issue.

46. That afternoon, at approximately 2.30pm, staff opened Ms Grant's cell door to give her some hot water and she ran out of her cell. She ran downstairs and refused to go back into her cell when staff ordered her to do so. Eventually, PCO C and the SPCO were able to walk Ms Grant back to her cell. The PCO recorded that Ms Grant was 'screaming her lungs out'. She went back a bit later and gave Ms Grant her PIN. Ms Grant was shouting and pushing at her window. The PCO asked her to come to the hatch to speak to her, and she seemed to calm down. She said she did not know where her daughter was, so the PCO suggested she should call someone to find out. Ms Grant tried to make a call, but it would not go through.

47. Ms Grant was locked in her cell for the night at around 5.20pm. At 5.30pm, the SPCO checked Ms Grant when he was completing the roll check. She was sitting on her bed, talking to herself but did not seem distressed. Approximately an hour later, a PCO referred Ms Grant to the mental health team because of her behaviour earlier in the day.

Emergency response

48. Shortly after 9.00pm, two PCOs started checking all the cell doors and completing a roll check as part of the handover between day and night shifts.

49. At approximately 9.05pm, PCO D looked through Ms Grant's cell door observation panel and saw she was lying on the floor and mostly underneath the bed. He told the investigator that it was not unusual for newly arrived prisoners to sleep under their beds and as Ms Grant had been behaving erratically, he was not initially concerned. However, within a few seconds, he decided to go back and check on Ms Grant. He banged on the door, but she did not respond.

50. PCO D called to a nurse who was on the landing and asked him to come and take a look. The PCO said he felt hesitant about going straight into the cell because of Ms Grant's earlier behaviour. The nurse looked in and the PCO radioed the night orderly officer for permission to enter the cell. The night orderly officer did not hear him at first, so the PCO tried again, and was then given permission to go into the cell.

51. Ms Grant's mattress was lying on the floor, pushed up against the door, but the staff gained entry eventually and pulled Ms Grant out from under the bed. Ms Grant did not respond to her name being shouted or physical attempts to rouse her.

52. At 9.14pm, once he realised that Ms Grant was not breathing, the nurse called a medical emergency code blue (used when a prisoner is unconscious or has breathing difficulties) and control room staff called for an ambulance.

53. The nurse asked PCO E to get his emergency bag while he and PCO D started chest compressions. When PCO E returned, the nurse asked him to get some oxygen while he applied the defibrillator which advised no shock. When the PCO came back with it, a nurse accompanied him.

54. Ms Grant's jaw was locked, she was cold to the touch, with some blood around her mouth and her trousers were wet. The nurse tried to insert an airway but was not successful. Staff delivered chest compressions and oxygen through a cylinder.

55. Paramedics arrived at Ms Grant's cell at 9.34pm. They inserted a nasal airway and continued chest compressions, but they could not resuscitate her. She was declared dead at 9.50pm.

Contact with Ms Grant's family

56. On 20 November, the prison appointed a family liaison officer. She visited the next of kin to break the news in person in the early hours of that morning.

57. Ms Grant's funeral was held on 12 January 2022. Bronzefield contributed to the costs of Ms Grant's funeral in line with national policy.

Support for prisoners and staff

58. After Ms Grant's death, the Director debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

59. The prison posted notices informing other prisoners of Ms Grant's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Ms Grant's death.

Post-mortem report

60. The preliminary post-mortem report concluded that Ms Grant died of cardiorespiratory collapse caused by the obstruction of the upper airway by a foreign body. The routine post-mortem examination was stopped when a pair of women's underwear was found in Ms Grant's upper airway. The operating pathologist indicated that she could not have placed the underwear there herself. The operating pathologist requested that a special post-mortem should be conducted by a Home Officer forensic pathologist. The forensic pathologist noted no signs of third-party assault or restraint and considered that it was consistent with a self-inflicted act.

Inquest

61. An inquest was concluded on 2 April 2025. A jury gave a narrative conclusion.

Findings

Assessment of Ms Grant's risk of suicide and self-harm

62. Prison Service Instruction (PSI) 64/2011 on safer custody provides guidance to staff on identifying prisoners who might be at risk of suicide and self-harm. It lists the risk factors and triggers that might increase a prisoner's risk and sets out the procedures (known as ACCT) that staff should follow when they identify a prisoner at risk of suicide and self-harm. Ms Grant had several risk factors for suicide and self-harm: it was her first time in prison; she had been charged with a violent offence against a family member; and she had a mental illness diagnosis (schizophrenia).

63. Ms Grant arrived at Bronzefield with a SASH form that said she was acutely psychotic and at high risk of suicide and self-harm. SPCO A saw the SASH form and passed it, along with the PER, to the interviewing officer, PCO A. He said he placed it on her desk with the other forms. When asked if he had read the SASH form, he said he would have done. He also said that he would have flagged it to the interviewing officer and asked them to consider opening an ACCT, though it would have been their decision once they had completed the interview.

64. PCO A told the investigator she did not see the SASH form. She said that she did not always see the PER either as sometimes the nurse kept it as they saw it first. She was aware of Ms Grant's offence but nothing else. She said that Ms Grant appeared calm at interview, and she had no concerns about her.

65. PCO B from the safer custody team also saw Ms Grant in reception. She told the investigator she did not see any paperwork. She thought Ms Grant seemed calm and had no concerns.

66. Nurse A, the Reception nurse, carried out Ms Grant's reception health screen. He told the investigator that he saw the PER but not the SASH form. He also saw the L&D report. However, he was satisfied that Ms Grant was not showing any signs of psychosis when he saw her and assessed that she did not need to be supported using ACCT procedures. He told the investigator that if he had seen the SASH form, he would have started ACCT monitoring.

67. Our first concern is that apart from SPCO A, none of the staff who saw Ms Grant in reception saw the SASH form that arrived with her. This was a crucial document that said Ms Grant was at high risk of suicide and self-harm. If either the interviewing officer or the reception nurse had seen it, it should have triggered the immediate opening of an ACCT. It is unclear what happened to it after the SPCO saw it. It would also appear that the SPCO did not flag it to the interviewing officer, so she was unaware of it when she did her reception screening interview.

68. We are also concerned that regardless of the SASH form, neither PCO A nor Nurse A gave sufficient consideration to Ms Grant's risk factors for suicide and self-harm. PCO A was aware of Ms Grant's offence, yet this is not mentioned as a risk factor in her NOMIS entry. He appears to have based her assessment that Ms Grant was not at risk of suicide or self-harm solely on her presentation, which she described as polite and calm. The nurse also seemed to base his assessment on Ms Grant's

presentation and lack of psychotic symptoms rather than her risk factors for suicide and self-harm.

69. In addition to staff's poor assessment of risk, we are concerned that reception procedures were poorly organised. As well as the SASH form apparently being temporarily mislaid, the Cell Sharing Risk Assessment (CSRA) form went missing entirely. Also, three separate first night forms were started for Ms Grant without explanation. We make the following recommendations:

The Director and the Head of Healthcare should ensure that reception staff:

- **are aware of the risk factors that might increase a prisoner's risk of suicide and self-harm;**
- **consider all relevant documentation that arrives with the prisoner, in particular the PER (and SASH form, if completed);**
- **base their assessment on a prisoner's known risk factors and not on their presentation;**
- **record the risk factors they have identified and their reasoning for not starting ACCT procedures; and**
- **retain the completed paperwork and store it securely.**

The Director should share this report with SPCO A, PCO A and PCO B and arrange for a senior manager to discuss the Ombudsman's findings with them.

The Head of Healthcare should share this report with Nurse A and discuss the Ombudsman's findings with him.

Location

70. After being alerted to the L&D assessment of Ms Grant and to L&D's email, the operational Head put arrangements in place for Ms Grant to be located in the prison's healthcare unit. However, Ms Grant was not placed there. Nurse A understood that it was up to him to decide where to place Ms Grant after carrying out the reception health screen. He said that he had read the L&D report but not the covering email that said the intention was to locate Ms Grant in the healthcare unit. He assessed that Ms Grant did not need to go to the healthcare unit and recommended she should be placed on a standard houseblock.

71. The clinical reviewer was concerned that Nurse A acted outside his role of reception nurse by overriding the decision to admit Ms Grant to the healthcare unit. When he carried out the screening of Ms Grant, he placed emphasis on how she seemed at the time and did not take account of the wider information available.

72. Healthcare's own Root Cause Analysis exercise highlighted that had Ms Grant been in the healthcare unit, it is more likely that an ACCT would have been opened, that she would have seen a GP and that she would have received oral antipsychotic medication. We recommend:

The Head of Healthcare should ensure that when senior staff indicate that a new prisoner should be located in the healthcare unit, the reception nurse is made aware and consults with senior staff if they propose to locate the prisoner on a standard houseblock.

Clinical care

73. The reception GP failed to assess Ms Grant or record why she had not done so. The next day, a prison GP was due to have a telephone appointment with Ms Grant, but he could not call her because her location was not showing on SystmOne, the electronic medical record. He would have had to access NOMIS, the case management system or ask a healthcare colleague or an officer to check for him.

74. The prison GP told the investigator he could not afford the time to investigate where Ms Grant was and, if nurses had any concerns, they should have brought her to him. We consider that neither doctor properly fulfilled their duty to ensure Ms Grant, a newly arrived prisoner with known mental health difficulties, was seen. We recommend:

The Head of Healthcare should ensure that:

- **newly arrived prisoners are seen by a GP if they are referred for a GP assessment; and**
- **if a prisoner is not seen, the GP records the reason in the prisoner's medical record and arranges for them to be seen as soon as possible.**

Emergency response

75. PSI 24/2011, Management and Security of Nights, says that under normal circumstances, the night orderly officer must authorise the unlocking of a cell at night and at least the minimum number of staff (as set out in local risk guidelines) should be present when it is opened. However, the PSI goes on to say that the preservation of life must take precedence and where there is or appears to be a threat to life, cells may be unlocked without the authority of the night orderly officer and a single member of staff can enter the cell alone, if they feel safe to do so.

76. We accept that Officer D may not have felt safe to enter Ms Grant's cell alone. However, we are concerned that once the nurse arrived, he radioed the night orderly officer for permission to enter. When interviewed, he maintained that permission from the night orderly officer was always required to go into a cell at night. We recommend:

The Director should ensure that staff understand that they can enter cells at night in medical emergencies without the permission of the night orderly officer in line with PSI 24/2011.

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