Investigation into the circumstances surrounding the death of a man at HMP Elmley in April 2008

Report by the Prisons and Probation Ombudsman for England and Wales

November 2009

This is the report of an investigation into the death of a male prisoner. He was found hanging in his cell at HMP Elmley in April 2008. At the time of his death he was a remand prisoner, having been returned to the prison on 19 February 2008 for breaching his bail conditions.

I extend my condolences and those of my colleagues to the man's family. I hope this report goes some way to answering any questions they may have. I deeply regret that my report is delayed and apologise for any additional stress that this may have caused.

Although there have been a number of natural cause deaths at Elmley, since the Ombudsman's office started investigating all deaths in prison custody in April 2004, this is only the second apparently self inflicted death. The other death occurred three months after the man who is the subject of this report, and I repeat a recommendation I made in that report with regard to the operation of the personal officer scheme at the prison.

The investigation into the man's death was undertaken by one of my investigators. He was assisted during interviews by one of my family liaison officers. In addition, a clinical review was conducted by a nominated doctor on behalf of Eastern and Coastal Kent Primary Care Trust (PCT). I am most grateful to the clinical reviewer. I would also like to thank all of the staff at Elmley for their cooperation with my investigation. I would particularly like to thank the Safer Custody Manager for his assistance.

It is evident from my investigation that the man was a quiet person who, for the most part, kept himself to himself. He was respectful and friendly to both staff and prisoners, working well as a wing cleaner. None of us are qualified to say what was on his mind during the last few weeks of his life, or be sure of the reasons why he took the actions that he did. However, it is evident that he had been experiencing a number of personal difficulties for several months before he entered prison.

I do not believe that staff at Elmley could have foreseen the man's actions. However, I make a number of recommendations including several relating to the delivery of mental health services and with regard to the completion of prison records by staff. I have also made a recommendation about the various procedures for checking and counting of prisoners during roll checks between the night and morning shifts.

Jane Webb
Deputy Prisons and Probation Ombudsman **November 2009**

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SUMMARY

Having appeared at court, the man was remanded into custody at HMP Elmley in February 2008. Court staff noted in his records that he had expressed suicidal thoughts and was at risk of suicide and they opened a Suicide Self Harm Warning Form.

Staff at Elmley were notified and, on his arrival, the man was placed on an Assessment, Care in Custody and Teamwork (ACCT) document. (The ACCT document is used to assess, observe and support prisoners at risk of harming themselves.) He was assessed by a nurse and the decision was taken for him to be located in the healthcare unit for further observation.

Whilst in healthcare the man continued to express thoughts of harming himself, telling staff that he would wait until he was released from custody before doing so. On 6 February, he was assessed by the prison medical officer, who recorded that, although he was in good physical health, he would nevertheless require an assessment by the Mental Health In Reach Team (MHIRT). A care plan offering appropriate support and interventions was prepared.

On 11 February, the man's referral to the MHIRT was discussed at a weekly meeting of the team and mental health primary care nurses. A member of the team attempted to assess him the following day. However, the assessment did not take place as he had been released by the court on bail.

Due to a breach of his bail conditions the man was rearrested and returned to Elmley on 19 February. Whilst he was in police custody, he again threatened to harm himself and so the escort officer opened a Suicide Self Harm Warning Form. During the reception process he was again assessed by a nurse who knowing him from his recent period of custody, decided that because of his brighter mood and hope for the future, it was not necessary for a second ACCT document to be opened.

The man spent his first week of his second period in custody on the induction unit before being located to houseblock 3 on 28 February, where he remained until his death. Staff described him as a quiet man who kept himself to himself and was polite to staff. As a trusted prisoner he became a wing cleaner and was moved onto C spur where he was given a single cell.

On 13 March, the man was seen by a nurse who noted that he was low in mood, was in a depressive state and at risk of harming himself. A referral was made for him to be reviewed by a member of the MHIRT. Although he was discussed at the meeting between the MHIRT and primary care he was not accepted for referral by the MHIRT and a decision was made for the primary care team to continue with his care.

The man was assessed by another of the prison's doctors on 19 March. The doctor prescribed an antidepressant and noted that the man had no thoughts of harming himself and no history of suicide. He had no further contact with healthcare staff and no interactions between him and discipline staff are recorded on his prison record. On the evening of 16 April, he took his meal to his cell as usual and gave some of

the items he had purchased from the prison shop to other prisoners.

At approximately 8.00am on 17 April, during unlock, a member of staff found the man hanging and the alarm was raised. A prison doctor who happened to be on the unit at the time attended to him along with a number of other medical personnel. However, the doctor confirmed that he was dead and so resuscitation was not commenced.

This report makes a number of recommendations, the most significant of which relate to the man's referral to the MHIRT and subsequent staff failure to record relevant information on his medical records. I also draw attention to poor record keeping and transfer of information between one department and another. I highlight the apparent failure of the personal officer scheme for, despite the man being in prison for two months, only one entry was made on his wing history sheet.

THE INVESTIGATION PROCESS

1. The investigation into the man's death was led by one of my investigators. He was assisted by one of my family liaison officer's, during staff interviews at the prison.

2. Notices announcing the investigation and its terms of reference were issued to both staff and prisoners. They were displayed around the prison and invited staff and prisoners to contact the investigators should they wish to do so.

3. The investigator visited Elmley and was given full access to all areas of the prison. The investigator obtained documentation relating to the time that the man spent at the prison, and interviewed a number of staff and prisoners who had had contact with him.

4. A clinical review was commissioned from Eastern and Coastal Kent Primary Care Trust, and a nominated doctor has kindly completed this on their behalf.

5. My family liaison officer contacted the man's father and uncle to discuss the purpose and scope of the investigation and give them the opportunity to raise any questions or concerns they had about the man's death. They identified a number of concerns:

   - Why was the man placed in a cell by himself?

   - Why was he left for such a long period of time without any observation?

   - He was known to suffer from depression. What was done to monitor and manage this?

   - Could anything more have been done to prevent his death?

   My family liaison officer also contacted the man's ex-partner to discuss the investigation. She questioned why he was not placed on "suicide watch" the second time he was in Elmley, considering that he had been on an ACCT a week earlier.

6. The man's family also asked why items that could be used by prisoners at risk of harming themselves were not removed from those deemed to be at risk. At the time of his death he was not subject to ACCT procedures and therefore such items were not considered for removal. The Prison Service Order (PSO) 2700 on Self Harm Management states that if personal items are to be removed from a prisoner's cell there has to be an ACCT review. This is because the removal of items from a prisoner at risk of self harm can often lead to greater distress.

7. I hope this report helps clarify the family's questions and any other issues that remain unclear and helps them to better understand what happened in the time leading to his death.

8. A copy of this report will be sent to the Coroner to assist him with his enquiries.

9. In response to the publication of the draft report the man's father reiterated his belief that, because the man was issued with a new prison number the second time that he was admitted to the prison, important information relating to his previous period in custody was not considered by staff. His father felt that this was a significant failing by the prison which ultimately resulted in the death of his son.

10. The man's ex-partner also responded to the publication of the draft report She commented that she believed when someone makes a point of saying they are not going to kill themselves when they are in prison this should be seen as a warning that the person is potentially at risk. She felt the very fact that the man seemed okay to staff was the biggest warning they could have received.

HMP ELMLEY

11. HMP Elmley, which opened in 1992, is a prison serving Kent and all courts in the county. Elmley holds just under 1,000 prisoners and is one of three prisons that make up the Isle of Sheppey prison cluster. The prison consists of five residential houseblocks, a healthcare unit and segregation unit.

12. Kent Prisons Mental Health In-reach Services have provided mental health services at Elmley and another seven Kent prisons since November 2003. An agreement between the prison and PCT resulted in all prison mental health services being commissioned from one body. Currently the Mental Health In-reach Team (MHIRT) provides services to eight prisons in Kent, including the Isle of Sheppey prison cluster.

13. For the first four years of its operation primary mental health care was provided by the Kent Prisons Mental Health In-reach Services. However, in 2007 the decision was taken for Elmley healthcare staff, with Registered Mental Nurse (RMN) qualifications to take responsibility for the primary mental health care role. All new mental health referrals at Elmley are assessed in the first instance by these mental health nurses. (At the time of the man's death there were two part time RMNs in post.) Having been assessed by the RMN, prisoners are referred to the MHIRT if, in the nurse's view, they have specific enduring mental health needs. Any member of staff or prisoner can ask for a referral assessment. The other duties of the RMNs are to identify a prisoner's risk of self harm and administer treatments to those suffering from depression. Such treatments mainly consist of prescribed medication. However, other treatments are provided when staff resources are available. They include one to one sessions and referring prisoners to other agencies such as substance misuse, chaplaincy and Listeners (prisoners trained by the Samaritans who offer a confidential listening service to other prisoners).

14. Mental health provision in Elmley and the Isle of Sheppey Cluster is currently subject to tender with the aim being that all mental healthcare, including primary care, will be provided by one organisation.

15. Currently a mental health liaison meeting takes place each Monday, when all referrals to the MHIRT are discussed. The meeting is attended by representatives from the Primary Healthcare Team, including Head of Healthcare and practitioners from the MHIRT. The meetings have recently been extended to include representatives of a number of other services and departments. Referrals made by the Primary Healthcare Team during the previous week, are discussed and a decision made as to the appropriate action to be taken. Urgent referrals are assessed immediately. Minutes of the meetings are taken and distributed to the relevant departments.

16. The last full inspection of Elmley, by Her Majesty's Chief Inspector of Prisons, was in 2006. She identified that there were weaknesses in the implementation of the Assessment, Care in Custody and Teamwork suicide and self harm procedures (ACCT). However she said many of the

weaknesses had been recognised and were being addressed. In general she said that Elmley provided a decent environment, but that some health services, including mental health care, were underdeveloped.

17. Her Majesty's Chief Inspector of Prisons also reported problems with the personal officer scheme. She said that officers generally had little meaningful impact on prisoners' lives. She cited poor entries on wing history sheets and prisoners changing personal officer when moving cells on the same houseblock. She reported that a newly implemented scheme was designed to change this situation and she made several recommendations to the Governor with regard to it.

18. The Independent Monitoring Board (IMB), in their annual report 2006/2007 said that the personal officer scheme at the prison was not working. The IMB observed that, due to the continual changes of staff, there appeared to be little chance for the scheme to function successfully. (IMB members are independent and unpaid. They monitor day-to-day life in the prison to ensure that proper standards of care and decency are maintained.) However, in their report of 2008, the IMB made no further reference to the operation of the personal officer scheme.

19. The same report noted that healthcare had had a challenging year. The IMB also reported that the Primary Mental Health team, which had been providing basic screening, was planning further recruitment and development of the service.

KEY FINDINGS

The man's first period in HMP Elmley

20. In February 2008, the man appeared at the Magistrates Court on charges of harassment and breach of bail conditions against his ex-partner. As a consequence he was remanded into custody at HMP Elmley.

21. The clerk of the court recorded on the man's Warrant of Commitment on Remand Before or After Conviction form, that the, "defendant expressed suicidal thought in open court – please refer to psychiatric services". The Duty Probation Officer recorded on a Notification of Custodial Remand form that the man was an ex-soldier suffering from depression and was a suicide risk. This same form records that at 3.30pm that afternoon the Safer Custody Manager at Elmley was informed of the situation.

22. Before he transferred to Elmley an Escort Officer opened a Suicide / Self-Harm Warning Form, indicating that the man was very depressed, wanted to "end it all" and had previously attempted to take his own life. (His ex-partner confirmed with my family liaison officer that the man, in the months leading to his imprisonment, both threatened and attempted to take his own life.)

23. During the reception process at Elmley the man was given the prison number VH7099. Staff recorded his personal details on page 1 of his Core Record F2050 (a prison reception record completed for all new prisoners). It was recorded that he had no fixed address. Lines were put through the areas of the form in which a prisoner's next of kin and emergency contacts are recorded. Staff also noted that his next court appearance was on 12 February.

24. An officer opened an ACCT document on the man in reception, noting that he was very low in mood. The officer recorded on the ACCT Immediate Action Plan that he should be located in healthcare and be observed every 30 minutes. A Cell Sharing Risk Assessment (CSRA) was completed, recording that he was considered suitable to share a cell. (A CSRA is used to assess the risk that a prisoner would present to others when sharing a cell.)

25. During the reception process the man was given a first reception health screen by a nurse. Her told the reception nurse that he had no issues with regard to his physical health or with substance misuse and that he had never received treatment from a psychiatrist. However he said that he had tried to harm himself the previous Saturday night (2 February) by taking an overdose of antidepressants and was currently thinking of harming himself again. The reception nurse concluded that the man was at a high risk of self harm and appeared very depressed. She referred him to the prison doctor and he was admitted to the healthcare unit for a full mental health assessment. (In his report the clinical reviewer notes that, on the Healthcare Admittance Form, the man was described as being "actively suicidal" and having "depression with suicidal ideation".)

26. Staff also opened an Induction Portfolio booklet. It included, in addition to a reception check list, a section to be completed by the member of healthcare staff carrying out the reception screening. The healthcare nurse wrote that it was the man's first time in prison and that he was admitted to healthcare as an inpatient. (The remainder of the Induction Portfolio was not completed.)

27. A preliminary mental health assessment was completed by healthcare staff on 5 February. It recorded that the man had previously worked in Iraq for a private security firm but denied that he was experiencing post traumatic stress disorder. He told staff that his current problems were triggered by relationship difficulties and he had been generally depressed since Christmas. He said that his relationship was irreparable and he had decided to end his life by taking an overdose. An ACCT care plan was completed, which included the involvement of the prison MHIRT.

28. The following day, 6 February, the man took part in an ACCT Assessment Interview and an ACCT Case Review. Despite his attempt to self harm on 2 February, he told staff that he had neither harmed himself nor previously attempted suicide. He said that, although he had thoughts of suicide, he intended to wait until he had been released from custody before killing himself. He said that he had no support from friends or family and wanted to die by using drugs and alcohol to do the "job properly". Later that evening during his ACCT Case Review, the man told staff that he would not kill himself in prison as it would not have the desired effect on "targeted" people, saying that he would kill himself when released from prison.

29. The man was seen by the prison doctor. The doctor recorded that he had good physical health but would require a referral to the MHIRT.

30. A second nurse completed a full Primary Care Mental Health Triage/Assessment, recording that the man was actively suicidal, depressed and not eating or drinking. She noted that he was currently taking antidepressants, but did not know what they were. She noted that he had recently locked himself in a hotel room and overdosed on prescribed medication as a consequence of relationship problems. The nurse drew up a further care plan for the man and made a formal referral for him to be reviewed by the MHIRT, providing a summary of his condition. (In his report the clinical reviewer notes that the care plan offered appropriate support and interventions.)

31. A member of staff from the Probation Bail Office at the prison, also reviewed the man that day and she too referred him to the MHIRT.

32. The man's ACCT was reviewed again by staff on 7 February. A Registered Mental Nurse (RMN) was the case manager. (The RMN told the investigator that he had only received foundation level ACCT training.) The RMN noted that the man denied thoughts of self harm and that there was a positive improvement in his presentation.

33. On 8 February, a third nurse completed a further Primary Care Mental Health Assessment on the man. He recorded that, although the man remained depressed and low in mood, he had been able to reflect on his problems. The nurse recorded that the man's risk of self harm had reduced and that interventions by the doctor and the Mental Health In Reach Team were appropriate.

34. In an ACCT review on 8 February, it was recorded that the man had stated he would not kill himself in prison. He said that he would take an overdose, as he had done before, and would plan it more carefully. The ACCT review team noted that he was at serious risk of self harm.

35. At an ACCT review two days later on 10 February, the man told staff that he no longer felt suicidal, but did not know what he would do when he was sentenced. Staff took the decision that he was to remain in healthcare until his return from court on 12 February, scheduling his next review for 15 February.

36. On 11 February, the man was discussed at the Primary Care Meeting at which new referrals from the primary mental health team are discussed with the MHIRT. The minutes record that:

> "[The man] – VH7099 – IPD – Seen and assessed by primary care. Low in mood, increased risk of self harm, he has significant death wishes. Action: [The mental health practitioner] is happy to assess."

Release on bail

37. On 12 February, the man was taken from Elmley to the Magistrates Court. Healthcare staff noted in his medical record that he was "out at court, may not return". He was granted conditional bail and released that afternoon. His bail conditions were that he was not to enter Kent or contact his partner, either directly or indirectly.

38. The mental health practitioner, with the prison's MHIRT, told the investigator that the man, who was not considered to be either an emergency or urgent referral, was referred to him on 11 February. The mental health practitioner said that he:

> "…planned to see him [the man] when I was next in the inpatient Department which would have been on the morning of 12 February 2008 (the next day). The referring team did not state that he was going to court on 12 February 2008 in the referral. The In-Reach team have no access to LIDS (the computerised inmate database), but Primary Care does have access and would have been aware he was going to court on 12 February 2008. When I attempted to assess him and found he had gone to court, I would have verbally informed the inpatient Department Manager and the Primary Care Team. I was not able to record my attempt to assess in the medical record as it would (and should) have accompanied him to court."

39. The Service Manager, for Kent Mental Health In Reach Services, told the investigator that the responsibility for recording decisions about individual prisoners, made at the Monday meetings, would lie with the Primary Care nurse who made the referral. He said that at the time of the man's death the MHIRT had no direct access to EMIS (the healthcare computer system).

40. The investigator asked the mental health practitioner why, having been unable to see the man on 12 February, the matter was not mentioned at the next Primary Care meeting on 18 February. He said that he was not present at the meeting and Primary Care had no representatives at the meeting, The third nurse having given his apologies. The mental health practitioner said, "The Primary Care meeting is for the Primary Care Team and as no one was in attendance from their team, none of their caseload would have been discussed." (In his report the clinical reviewer says that,

> "At first reception in Elmley, the seriousness of [the man's] mental state was recognised and all appropriate agencies were alerted. The speed of response was impressive and the support and supervision exemplary.")

Return to HMP Elmley

41. Due to a breach of his bail conditions the man was rearrested and returned to Elmley on 19 February, having been out of prison for a week.

42. Information was sent from a police custody sergeant at the local Police Station the escort officer at the Magistrates Court. The PCSO completed a Suicide / Self Harm-Warning Form. He ticked a number of statements on the form indicating that the man had made statements of intent to self harm/commit suicide, seemed very depressed and had attempted to harm himself in the last six months. The man arrived at Elmley at 3.45pm and a senior officer signed the form acknowledging that he would be kept safe according to local protocols until passed to the reception nurse for assessment.

43. During the reception process at Elmley the man was given a new prison number, VH7202. He told staff his address It was noted that he had no next of kin and he did not provide a name of a person to be contacted in an emergency. Staff noted on his record that he had previously been discharged from Elmley on 12 February.

44. A Cell Sharing Risk Assessment was started by an unidentified reception officer. It noted that the man's prison number was VH7099, his original prison number. However this was overwritten with the new prison number VH7202. (Although he should have been allocated his old prison number on his return to Elmley, the investigators have been unable to establish why this was not the case.)

45. An officer completed the CSRA, recording in section 1 of the form that he had received previous documentation, including an ACCT document, but that it had been closed. The officer who completed the CSRA told the investigator

that he could not recall whether or not he passed the ACCT to the reception nurse, adding that otherwise it would have remained in the man's core record. In section 2 the officer who completed the CSRA did not indicate either yes or no to the question, "does the prisoner have an open 2052SH?" (Which is another name for an ACCT), thus indicating that there was evidence of his having a previous ACCT document. When asked why section 2 of the CSRA was not completed, the officer said that it was probably because the healthcare nurse had receipted the warning form and had not decided, at that stage, whether an ACCT document was necessary.

46. The officer who completed the CSRA also indicated on the man's wing history sheets that the CSRA had been completed and that he was not issued with a PIN phone number due to the nature of his offence of harassment. He was subject to the restrictions outlined in Prison Service Order (PSO) 4400 Prisoners Communications and Use of Telephone. It was also recorded that the man was a non smoker. No further comments are recorded in his wing history sheets from that date until the day of his death.

47. The man was assessed by an RMN at 6.15pm. The RMN told the investigator that he remembered the man from his time in prison a week earlier. The RMN indicated on the Suicide / Self-Harm Warning Form that, having reviewed him, an ACCT was not opened. In section 3 of the CSRA the RMN indicated that, following the self-harm assessment, no concerns were raised about the man

48. The RMN completed a First Reception Health Screen. He recorded that the man had been in prison previously and had no concerns with regard to his physical health. The RMN recorded the man's previous attempt to commit suicide by overdose, due to the break up of a relationship.

49. The RMN noted in the man's clinical record that he, "appears brighter in mood than when last admitted and is quite hopeful for the future with regard to his court hearing". The nurse said he discussed the man with the officer who completed the CSRA and they decided that he would be fit for normal location.

50. The investigator asked the RMN why he made hand written notes of his assessment of the man and had not used EMIS to record the assessment. He said that the reason nurses did not use EMIS directly was, "due to the pressure of work". He said that, as he was seeing so many prisoners, he did not have enough time to enter the details of meetings onto EMIS.

51. The man spent the first week of his return to Elmley on houseblock 1, (the induction centre), before moving to houseblock 3 on 28 February. Whilst in the induction centre a bail information officer interviewed him as part of reception procedures. He told her that he did not wish to make a bail application and would be "sticking it out". The bail information officer says that the man told her he had no thoughts of harming himself.

52. On 1 March, in an unaccredited entry in the Wing Observation Book, a member of staff reported that the man had been sick over his bed. One of the

houseblock officers told the investigator that the man had been feeling unwell. The houseblock officer described his cell as untidy, considering that he was an ex-Royal Marine. The houseblock officer asked him directly if he was thinking about harming himself, but he denied it and said that he had no problems.

53. On 13 March, as a consequence of being seen by a nurse that morning, the man was assessed by the prison doctor. The prison doctor noted in the man's medical record:

> "Patient has typical symptomatology of depression see Inmate Medical Record (IMR). This patient should do well on formal treatment Ref to RMN / In Reach Not suicidal."

He wrote that, although the man was suffering from the symptoms of depression, he was not suicidal and referred him to the MHIRT. He wrote on the referral form that he had symptoms of major depression, was crying spontaneously and suffering from disturbed sleep. (In his report the clinical reviewer notes that, in the record of referrals made to the MHIRT, for February to March, no referral was sent by the prison doctor).

54. The third nurse visited the man on Houseblock 3 later that day. He wrote in his medical record, noting a similar comment in his care plan which the nurse opened on 8 February, that he was:

> "Back in prison, Remains much the same in his mental health condition. Low mood – depressive state and risk of self harm. Not eating well and not sleeping well, discussed with Dr plan for In-Reach to see A.S.A.P."

55. There are no records to substantiate whether or not the man was assessed by the MHIRT after the referral by the prison doctor or what the outcome was. However, on 17 March, he was discussed again at the Primary Care Meeting. Minutes of the meeting note, under a heading of "Secondary care referred to Primary care":

> "None identified this week, however two primary care assessments were left in the In-Reach team office – Mr L and [the man], both to be accepted back by primary care."

56. The Healthcare Manager told the investigator that prisoners not accepted by the MHIRT for treatment remain on the caseload for primary mental health staff. She said that treatment options are discussed with the doctor.

57. The Service Manager for Kent Mental Health In Reach Services, told the investigator that, although records of referrals are kept by the MHIRT, they are only listed as a referral once it has been accepted at the Monday meeting. He said that if the referral is not accepted for assessment by the MHIRT, the referral is not recorded. He said that at the time of the man's referral only a verbal discussion would have taken place at the meeting. The Healthcare Manager told the investigator that all referrals were brought to and discussed

at the referral meetings.

58. On 19 March, the man was seen by another of the prison doctors. This doctor wrote in his medical record that he was depressed but not suicidal. He noted that he had "no thoughts of deliberate self harm" and that there was "no history of overdose" and no "past history of suicide". The doctor prescribed Sertraline Hydrochloride, (an antidepressant medication) and Nytol, (to aid sleep). No further entries were made in the man's medical record until the day of his death.

59. The investigator has been unable to establish in any detail what happened to the man during his second period of custody at Elmley. However, Two officers on houseblock 3 told the investigator that he had been a kit orderly whilst he was on B spur and had occupied a three man cell. He was moved to a single cell in C Spur on becoming a wing cleaner, a job which is only given to trusted prisoners. The houseblock officer said that the man presented no problems and kept himself to himself. He said the man was respectful to staff and described him as being determined in character. The houseblock officer said that he showed no signs of his intent to self harm and, had he noticed any, he would have opened an ACCT. The houseblock 3 SO described him as being a quiet individual but confident and self-reliant.

16 to 17 April

60. A prisoner who knew the man, told the investigators that he believed he was one of the last to see him on the evening of 16 April. The prisoner described the man as being quiet, keeping himself to himself, not causing any trouble, polite and well mannered. The prisoner said that the man gave some of his canteen (goods including tobacco, confectionery and other food stuffs purchased from the prison shop) away that evening to other prisoners and had recently talked about life after death and the spirit world. However the prisoner did not report either matter to prison staff.

61. A second prisoner, who shared a cell with the man on B Spur, told the investigators how the man had changed from the first time he had been in Elmley, describing him as a "shadow of himself". He said that he gave him some of his canteen, hugged him and told him "you'll be ok". I understand that this prisoner did not tell staff about the man's behaviour either.

62. The second houseblock 3 officer said that he saw the man at about 5.00pm, returning to his cell with his meal, but did not speak with him. The officer also described him as a quiet man who kept himself to himself.

63. An Operational Support Grade (OSG) arrived on duty on HB3 at 8.30pm and completed a roll check and handover with the officer he was relieving. The OSG told the investigator that the roll check involved counting each prisoner. The OSG said that he was not required to solicit a response from a prisoner adding, "…You're just there to count the physical body of the person.", the OSG said prisoners who were sleeping would not be woken. He completed his roll count at around 8.45pm to 9.00pm. He said that he saw the man in

the single cell that he occupied on his own, at 8.30pm that evening and had never spoken with or seen him before. When asked if he could recall seeing him that night, the OSG said no, he recalled just seeing a person in the cell.

64. During the night the OSG completed his pegging (pegging is an electronic system used to record an officer's movements on a wing at night.) The OSG said that the pegging routine involved visiting each of the spurs every 45 minutes to an hour throughout the night.

65. The pegging records show that between 0.46am and 6.08am no pegging was recorded. The investigator made enquiries with the Deputy Governor of Elmley, seeking confirmation with regard to the reliability and accuracy of the records. The Deputy Governor said that he had no reason to doubt the accuracy of the reports and was unable to speculate as to why no pegging was recorded for about five hours during the night. However, the Deputy Governor added that there were doubts as to the efficacy of the pegging system in place at the prison.

66. A prisoner in the cell next door to the man told the police that he went to his cell sometime between 7.00pm and 7.30pm. He said that he heard a loud bang between 4.00am and 5.00am which woke him up. Not thinking any more of the noise, he went back to sleep. He said that he was checked at about 7.00am during the early morning roll count and again at 8.00am, around the time the man was discovered.

67. The first prisoner also said he was woken by a noise between 4.30am and 5.00am on the morning of 17 April. Unlike the prisoner next door to the man, he could not recall being counted or checked during the morning roll.

68. In addition to pegging the OSG carried out routine patrols and checks throughout the night, checking the two prisoners on open ACCTs and a prisoner considered as a high escape risk. The OSG said that he answered approximately 25 to 30 cell bells during the night, all from B Spur, (the recently opened detoxification wing) and that no bells were called on A and C Spurs that night. The investigator requested a record of cell bell activations for the wing that evening. However, the Deputy Governor advised him that the cell bell system was not connected to software which was able to record when bells were rung and when they were switched off. As a consequence the investigator was unable to establish how many bells were rung on the unit that evening. (I understand that both the pegging and cell bell systems at Elmley are being updated as part of a two year refurbishment programme.)

69. A nurse was also based on houseblock 3 that evening, in order to attend to the prisoners on the newly opened detoxification spur, should the need arise. She was based in the nurses' station in the administration suite just off the main wing spurs. The houseblock 3 nurse told the investigator that, although she had contact with the OSG on several occasions that evening, she did not assist him respond to any cell bells that night nor did she go on to the unit itself.

70. When the investigators asked the OSG whether or not there was a nurse on duty that evening, he said that he had "No comment to make about the civilian staff." The OSG said that he did not know the rank or name of the person on duty because they were not Prison Service personnel and he never spoke to them.

71. In the early morning of 17 April, the OSG said that he was required to provide a full roll check by 6.00am. He commenced his checks at 5.40am, reaching the man's cell at about 5.45am. The OSG said he saw the man lying in his bed at this time. He told the investigator that he was not required to get a response or wake prisoners whilst carrying out his roll checks. The OSG said that he confirmed the houseblock roll at about 6.00am, 15 minutes after it began.

72. Having confirmed the roll, the OSG began to wake prisoners required to attend court between 6.05am and 7.00am in preparation for collection from the wing. He said that two officers arrived to collect the prisoners.

73. The OSG explained to the investigator that he would normally be relieved from his duties at about 7.30am. However, no relief arrived that morning and he contacted the night orderly officer. He was told that someone had been rostered to relieve him, but they had not arrived at work. The safer custody manager arrived on the houseblock at the same time. The OSG discussed the previous night's shift with him and completed the houseblock Night Patrol Checklist, entering the evening and morning rolls.

74. An officer arrived on houseblock 3 at about 7.35am, having swapped shifts with another officer. She said that the OSG was talking to the safer custody manager when she arrived. The OSG asked her if she was the "early start", but she said that she was not. However, as the houseblock 3 officer was the first day officer to arrive she proceeded to check the prisoners who were on ACCTs and the escape list prisoners.

75. The houseblock 3 officer said that she did not actually count the prisoners on the houseblock that morning, due to insufficient time and because other jobs required attention. She signed the night shift paperwork and the safer custody officer allowed the OSG to leave the wing.

76. The houseblock 3 senior officer (SO) told police that he commenced duty at 7.45am as the SO on duty that day. He said that all the staff were present when he arrived, as was another SO colleague. The SO checked that the roll had been counted and signed for by the houseblock 3 officer, who he believed at that point had been the early patrol officer. The SO then checked the observation book for any significant events that had occurred the previous evening (there were none) before briefing his staff.

77. A second houseblock 3 officer told police that he started duty at around 7.45am. He told the investigator that, when he arrived on the houseblock, the night OSG had already left. He attended the regular briefing and was detailed to work on C spur with the first houseblock 3 officer. He said that there were

no concerns reported about the man in either the observation book or the briefing.

78. At approximately 8.00am the SO instructed the staff to unlock the prisoners. The first houseblock 3 officer commenced unlocking C spur, along with the second officer. The first officer said that the second cell he unlocked was the man's, which was the second cell on the spur. When he looked into the cell, he saw the man suspended from his upturned bed. A sheet was tied around his neck with the other end tied to the top of the upturned bed.

79. The second houseblock 3 officer told the police that he shouted out to the first officer to lock up again and raised the alarm. The SO colleague radioed for assistance as he made his way to the man's cell before ordering the relocking of the houseblock.

80. The second houseblock 3 officer and the SO went into the cell. The SO recalled that the cell bed was standing on its end with the man, slumped, half sitting with his back to the cell wall and with a ligature around his neck. The SO lifted him in order to reduce the weight on the ligature, while the second officer cut the ligature with an anti-ligature knife (known as a 'Fish Knife'). The SO lowered him to the floor and noticed that he was "stone cold".

81. The first houseblock 3 officer relocked her side of the spur then went to the man's cell to see if she could assist her colleagues, but she found the situation too distressing and left the houseblock.

82. A nurse, who was on the houseblock at the time, arrived at the cell before returning to the central office to collect the emergency response bag. The SO was about to commence resuscitation at about 8.01am when a doctor arrived, followed by a healthcare principal officer (PO).

83. The doctor on scene happened to be visiting the houseblock at the time that the man was discovered. He was informed of the situation and went to the cell soon after the SO and second officer. A number of other staff, including nurses, also responded to the emergency.

84. The PO told the investigator that she arrived at the cell after the nurse on scene who was outside opening the response bag. The PO went inside to find the doctor already there, kneeling by the man. The PO told the investigator that the doctor:

> "… was examining [the man], he'd got his stethoscope out and was listening to see if there was any heart sounds. I said to him 'do you want us to resuscitate because you know we need to start straightaway if you do' and he replied to me, 'no, he's dead, feel him he's cold' and I did feel him and he was cold."

85. The PO said that she also checked the man for signs of life but that there were none. She said:

"I noticed that there was no pupil reaction and also that the eye was dry, which is a sign that someone has been gone for some time."

86. The doctor on scene later wrote in his incident statement "examined [the man] very, very cold, no heart sounds and pupils dilated, fixed, no pulses felt". The doctor announced that he was dead and then left the cell with the PO at 8.05am.

87. Several notes were left in the man's cell, although it is not clear who they were intended for. He had written on one of the notes that he was sorry.

88. Some of the staff who discovered the man and who responded to the emergency were invited to a hot-debrief that morning. (A hot-debrief is a meeting held as soon as possible after a major incident.) However, the OSG, the first houseblock 3 officer and the PO did not attend.

89. The safer custody manager asked for all prisoners on open ACCTs to be reviewed. I also understand that the staff care and welfare team approached those members of staff who had been involved in the events of the morning and that this was appreciated by staff.

90. The man had left no next of kin details and so staff searched for an alternative contact in his prison record. The contact details of the man's ex-girlfriend were found at approximately 9.25am. Because she had been the victim of his alleged offence, the Governor sought advice from Kent Police. The decision was taken to inform his ex-girlfriend of his death.

91. The reverend, Elmley's family liaison officer, and the Governor travelled to inform the man's ex-girlfriend of his death at 12.15pm. The Governor spoke with the man's father later that afternoon, having obtained his contact details from the man's ex-girlfriend. His father visited Elmley on 25 April where he was able to view his son's cell. The funeral took place on 7 May and the reverend officiated. The funeral was attended by the Governor.

ISSUES

Clinical care

92. In his report the clinical reviewer says,

> "[The man appeared to have had a well established depressive illness related to relationship problems before he was remanded in custody to HMP Elmley on 5 February 2008."

As I have already said, the clinical reviewer describes the medical support that the man received in prison during his first period in Elmley as impressive.

93. When he was first in the prison, he was admitted to healthcare and referred to the mental health in reach team. However, the man went to court and was released on bail before the team could assess him. I am concerned that no record was made of the attempt to contact him either on his medical records or the MHIRT records. It is essential that all contact with prisoners, successful or otherwise, is recorded. Although I understand that the MHIRT now have access to the EMIS computer system and can record their contact with prisoners directly, I am still minded to make the following recommendation.

The Heads of Healthcare and the MHIRT should remind all staff of the importance of recording their contacts with prisoners, successful or otherwise, either on EMIS or in the prisoner's records.

94. In order that the MHIRT can ensure that referrals are appropriately assessed, it is essential that adequate records are kept, including whether further action is necessary. It is likely that, had there been adequate records, staff such as the nurse who assessed the man on his return, would have been aware that the MHIRT had not managed to assess him and referred him back again.

95. Similarly when the man was referred to the MHIRT during his second period of custody, the referral was not recorded by the team and there is no evidence to suggest that he was seen by them. He was discussed at the Primary Care Meeting on 17 March but a record was not kept as the referral was rejected. I do not believe it appropriate that rejected referrals, and the reasons for the refusal, are not recorded.

The Heads of Healthcare and the MHIRT should satisfy themselves that procedures are in place to ensure that all referrals made to the MHIRT are recorded, including the outcome.

96. During the second reception healthscreen, the RMN made a handwritten entry on the man's medical record but did not repeat it on EMIS. He explained to the investigator that pressure of work meant that the nurses did not have time to complete the entries.

97. As well, there was no record on EMIS or the man's medical records of the ACCT document opened during his first period of custody, even though it had been reviewed by nursing staff. When he returned to Elmley, the RMN only knew about his self harm history because, coincidentally, he was involved in the ACCT during his first period in custody. Had a different reception nurse been on duty, there would have been no record to inform them. The nurse would not have been equipped to make an informed decision about re-opening the ACCT document. It is essential that all the contact between nursing staff and prisoners is recorded to ensure that other healthcare personnel can read the full medical history.

The Head of Healthcare should remind all healthcare staff working in reception to record all interactions with prisoners on EMIS.

98. The prison doctor referred the man to the MHIRT on 13 March, writing that he was suffering from major depression, crying spontaneously and had disturbed sleep. However he did not indicate the priority that the referral should be given. In his report the clinical reviewer says:

"I cannot identify on [the prison doctors] referral form to the Mental In-Reach team a level of priority assigned to [the man]. The Prison mental Health Service Level Agreement identifies three levels of referral: emergency, client to be seen with 24 hours, urgent client to be seen within seven days, non urgent client to be seen within 15 working days."

The Healthcare Manager should remind all healthcare staff to identify a level of priority when referring prisoners to the MHIRT.

99. In his report the clinical reviewer comments that:

> "The speed with which the Inreach Mental Health Services responded or rather failed to respond to the prison doctors referral of 13 March should also in my opinion be called into question. [The man] was "accepted back" at the meeting of 17 March, but nothing seems to have happened in terms of mental health support.

100. The second prison doctor saw the man on 19 March, a week after the first prison doctor made the referral, and prescribed medication. The clinical reviewer comments that, although the second prison doctor's clinical assessment was similar to that of the first, some of the former's records were factually incorrect. The clinical reviewer remarks that this may have been because The second doctor relied on the man's own account of his history, rather than on the medical records.

101. The clinical reviewer comments that prescribing Sertraline as an antidepressant was entirely reasonable. However, the National Institute for Health and Clinical Excellence (NICE) guidelines, "recommend(s) that during the first four weeks of treatment with this form of medication, especially in patients with suicidal thoughts, that close supervision is necessary".

102. The clinical reviewer goes on to observe that:

> "As far as I can determine from the medical record, [the man] was not given any follow-up appointments for review, nor seen again by a healthcare professional between his consultation with the second prison doctor on 19 March and [the man's] death on 17 April.
>
> Whilst the medical officers concurred on the nature and severity of [the man's] mental health problems, the level of supervision, certainly after the consultation of 19 March 2008 was not in my opinion commensurate with the seriousness of [the man's] problems nor with the medication prescribed on 19 March."

The Healthcare Manager should remind all the doctors to review regularly, and according to NICE guidance anti-depressant medication prescribed to prisoners.

103. There were only two part time RMN's working in the primary care team at the time of the man's death. The healthcare manager told the investigator that the majority of their time was spent completing MHIRT referral assessments. As a consequence they had little time to provide programmes and treatments for prisoners suffering from depression, anxiety and other mental health issues who were not accepted by the MHIRT. She said that prisoners with depression were mainly treated with prescribed medication and referrals to other agencies such as the chaplaincy, substance misuse services and Listeners supported by the Samaritans. The RMNs lacked the time to provide any other support for such prisoners.

104. The investigator invited the clinical reviewer to comment on this situation, given that Elmley has a population of around a 1,000 prisoners, but he felt unable to comment on commissioned services and staffing levels. Nevertheless I believe that such limited primary mental healthcare provision is inadequate for a large local prison. Although the clinical reviewer was unable to comment in detail, he acknowledged that there appeared to be performance and commissioning issues which should be addressed by the PCT.

The Heads of Healthcare and the MHIRT should undertake a needs analysis and review of mental health provision, including staffing levels, and satisfy themselves that the appropriate mental health provision is being delivered.

Assessment, Care in Custody and Teamwork

105. The clinical reviewer comments that, although the man's history of self harm was recognised when he went back to the prison on 19 February, "the same support mechanisms which had worked so well on his first remand were not put into place on the second occasion".

106. The RMN acted as the Case Manager and led the man's first ACCT review, despite having only been trained to foundation level. PSO 2700 on Suicide Prevention and Self-Harm Management, introduced in April 2008, is clear. Section 1.15.1 of the PSO states that:

> "ACCT Case Managers must be minimum grade of Senior Officer or Nurse Band 5 and have successfully completed the training for ACCT Case Managers …"

107. I make no criticism of the way the RMN led the review. However, I am disappointed to learn that a nurse, who regularly works in reception and is expected to lead case reviews, has not been trained as an ACCT Case Manager.

The Governor and Healthcare Manager should ensure that all staff required to act as ACCT Case Managers have completed the mandatory ACCT Case Manager course.

108. The ACCT opened on the man during his first week in prison was of good standard but there was little continuity of care. PSO 2700 states at paragraph 19 Annex 8G that:

> "Whenever possible the Case Manager should arrange subsequent reviews at a time that he or she can be present, in order to provide some continuity of care for the prisoner. Where the named Case Manager cannot attend, they must explain to the prisoner who is to take their place at the review, and record that they have done this."

109. Of the four ACCT case reviews that took place on the man that week, only one was led by the same Case Manager and different members of staff attended the reviews. I believe that this may well have undermined the level of understanding of his needs. The Case Manager allocated to a prisoner at risk should remain the same, as far as is possible, for the duration of the ACCT document so that the prisoner at risk receives consistent support from familiar staff. Although I do not consider that the lack of continuity had any bearing upon his eventual actions, I make the following recommendation.

The Governor should ensure that the Case Manager, and where possible other attendees, remain the same for the duration of the ACCT document so that the prisoner receives consistent support from familiar staff.

110. The officer completed the Cell Sharing Risk Assessment (CSRA) on 19 February, the day that the man returned to Elmley. He recorded that he had received a closed ACCT document on him but did not indicate in the second section that the previous ACCT document had been closed. The officer told the investigator that this was, "Probably because healthcare had [the] warning form and had not decided whether an ACCT document needed to be opened." He could not recall passing the ACCT document to the reception nurse, adding that if he had not done so, it would have been placed in the man's

prison record.

111. As I have said, the reception nurse decided, albeit after discussion with the officer who completed the CSRA, not to re-open the ACCT document as the man was "… brighter in mood … and is quite hopeful for the future …". Although I do not question the RMN's decision, I am concerned that the investigator was unable to establish what happened to the ACCT document after the officer noted its receipt on the CSRA. I am also concerned that the officer appears to have believed that it was the nurse's responsibility to decide whether to reopen the ACCT.

The Governor should remind reception staff of the importance of checking the status of ACCT documents for prisoners returning, either through recall or breach of bail. Consideration should be given to issuing guidance on the procedures to be followed when the ACCT documents have not been closed.

112. My enquiries reveal another gap in the communication in reception. Although the officer who completed the CSRA acknowledged receipt of the Suicide and Self-Harm Warning Form, the RMN says that he did not see it, and as such was unable to consider its contents whilst completing the man's health screen. Information recorded on such forms is worthless unless it is passed safely to those who require it to carry out their duties. It is imperative therefore that Suicide and Self-Harm Warning Forms are passed from reception officers to nursing staff in order that appropriate consideration of their contents can take place.

The Governor should review the process for receiving and transmitting Suicide and Self-Harm Warning Forms with a view to ensuring that their presence is drawn to the attention of the healthcare screener.

Wing history sheets

113. The investigator was unable to establish any detail about the man's second period of custody and so I am unable to answer many of the questions asked by his family. Only one entry was made on his wing history sheets, and that was made on 19 February, the day that he returned to prison. I am very concerned that no further entries were made. The SO on houseblock 3 said that officers should make at least weekly entries in history sheets and significant entries should be highlighted in the wing observation book. In this man's case, neither happened.

114. The absence of entries included the failure to record that there was a Suicide and Self-Harm Warning Form thus preventing wing staff access to this important information. The SO told the investigator that wing staff rely on reception staff to note whether a prisoner was at risk of harming themselves.

The Governor should remind all staff of the importance of completing wing sheets and observation books, noting their interactions with

prisoners and other pertinent information.

Personal officers

115. It became apparent during the investigation that one reason there were so few entries in the man's wing history sheets was uncertainty about who his personal officer was. In the Ombudsman's report into the death of another prisoner at Elmley, three months after this man's, the investigator also reported deficiencies with the personal officer scheme, as have Her Majesty's Inspectorate of Prisons and the IMB. I repeat the recommendation made in the report, which was published in June 2009.

The Governor should satisfy himself that the Personal Officer Scheme is operating properly and in accordance with the local protocol.

Allocation of prison numbers

116. The man was rearrested and returned to Elmley where he was given a new prison number by reception staff. Prisoners released on bail and returned to prison for breaching their bail, and for the same offence, should be given their original prison number.

117. The investigator has been unable to establish why the man was given a new number even though the first page of his personal summary sheet records that he had been released on 12 February. I also note that his original number was overwritten with the new number on the CSRA completed on his return.

118. Although I make no formal recommendation, I suggest that the Governor reminds reception staff to reallocate previous prison numbers to prisoners recalled for the breaching their bail conditions.

The morning roll checks on 17 April

119. Two prisoners in the neighbouring cells reported hearing a loud bang in the early hours of the morning, between about 4.00am and 5.00am. The OSG told the investigator that he began his roll check at 5.40am and reached the man's cell about five minutes later. He saw him lying in his bed. The OSG told the investigator that he was not required to wake or solicit a response from prisoners whilst completing the roll check.

120. Having confirmed the houseblock roll at 6.00am, the OSG began to wake the prisoners going to court. The first day member of staff arrived at about 7.35am. She did not have time to carry out the second roll check of the morning but signed the night shift paperwork to indicate that she had.

121. The investigator has been unable to establish the exact time when the man took his life. However the SO said that he was "stone cold" and his arms were mottled in appearance, suggesting that he had been dead for some time. Even though the prisoners referred to hearing a bang between 4.00am

and 5.00am, the OSG said that the man was lying on his bed at 5.45am, which means that he must have taken his life some time afterwards.

122. I cannot say with any certainty exactly what happened in the early hours of the morning and the time that the man died. However, I am concerned by a number of aspects of the morning roll checks.

123. The prison's night patrol procedures, paragraph 17 of Know Your Job Sheet 67, state that night staff should carry out their early morning roll check at 7.00am, reporting the roll to the night orderly officer at 7.30am. However, the OSG carried out the early roll check at 5.45am, which is 75 minutes earlier than required.

124. The OSG told the investigator that he only counted the numbers of prisoners in the cells when he conducted the check and did not solicit a response. This is contrary to paragraph 5 of the night patrol procedures which state that, "In the event that a prisoner is asleep you will wake him and obtain a response from him."

125. My final concern is that the first houseblock 3 officer signed for the roll check that morning without actually carrying out the check. This was clearly in breach of procedures.

126. It is imperative that staff complete roll checks and that they follow the prison procedures when doing so.

The Governor should remind all staff that roll checks should be carried out at the scheduled time, a response should be solicited from the prisoner and officers verifying the roll should only do so when they have completed the check themselves.

CONCLUSION

127. The man had recently taken an overdose when he first came into prison and he was experiencing a number of emotional problems. Staff immediately identified that he was actively suicidal and suffering from depression. The support and care during his first week of custody, which was in healthcare, was described by the clinical reviewer as exemplary. The Assessment, Care in Custody procedures were put in place and remained open throughout. He was referred to the mental health team but released on bail without being assessed.

128. When the man returned for the second time at Elmley, the reception nurse considered that he was not at risk of self harm and the ACCT procedures were not reopened. He was located on a normal prison wing and was described as keeping himself to himself. The mental health referral was not reopened either and the prison records tell us little or nothing about the following two months. Although I believe that staff could not have foreseen his actions, I am concerned that these omissions meant that he was not supported by either ACCT or the mental health team, both of which might have prevented him taking his life.

RECOMMENDATIONS

1. The Heads of Healthcare and the MHIRT should remind all staff of the importance of recording their contacts with prisoners, successful or otherwise, either on EMIS or in the prisoner's records.

   Accepted – All departments and service providers aware of the importance of accurate documentation on EMIS.

2. The Heads of Healthcare and the MHIRT should satisfy themselves that procedures are in place to ensure that all referrals made to the MHIRT are recorded, including the outcome.

   Accepted – Robust referral system now in place, all assessments and outcome are documented accordingly and scanned onto EMIS

3. The Head of Healthcare should remind all healthcare staff working in reception to record all interactions with prisoners on EMIS.

   Accepted – Medical records are now entirely computerised.

4. The Healthcare Manager should remind all healthcare staff to identify a level of priority when referring prisoners to the MHIRT.

   Accepted – In conjunction with MHIRT Referral Forms to be altered to address priority of referrals.

5. The Healthcare Manager should remind all the doctors to review regularly, and according to NICE guidance anti-depressant medication prescribed to prisoners.

   Accepted – Notice to Drs highlighting NICE guidelines re prescribing of antidepressants.

6. The Heads of Healthcare and the MHIRT should undertake a needs analysis and review of mental health provision, including staffing levels, and satisfy themselves that the appropriate mental health provision is being delivered.

   Accepted – Mental health services currently being tendered. Three additional primary mental health nurses employed via KMPCT to address service shortfall.

7. The Governor and Healthcare Manager should ensure that all staff required to act as ACCT Case Managers have completed the mandatory ACCT Case Manager course.

   Accepted – All current Healthcare Managers have completed the ACCT Managers course.

8. The Governor should ensure that the Case Manager, and where possible other attendees, remain the same for the duration of the ACCT document so that the prisoner receives consistent support from familiar staff.

Partially Accepted – Where possible, we will endeavour to ensure that the case manager remains the same, due to operational pressures it will not be possible for all attendees.

9. The Governor should remind reception staff of the importance of checking the status of ACCT documents for prisoners returning, either through recall or breach of bail. Consideration should be given to issuing guidance on the procedures to be followed when the ACCT documents had not been closed.

Accepted – The Head of Security will write to each member of the reception team reminding them of the importance of checking the status of the ACCT document.

10. The Governor should review the process for receiving and transmitting Suicide and Self-Harm Warning Forms with a view to ensuring that their presence is drawn to the attention of the healthcare screener.

Accepted – This work is now carried out by dedicated multi disciplinary staff in the First Night Centre.

11. The Governor should remind all staff of the importance of completing wing sheets and observation books, noting their interactions with prisoners and other pertinent information.

Accepted – A Notice to Staff to be published on a twelve monthly basis.

12. The Governor should satisfy himself that the Personal Officer Scheme is operating properly and in accordance with the local protocol.

Accepted – Review of the Personal Officer scheme to be commissioned by the Head of Residence, to be completed by 30 November 2009.

13. The Governor should remind all staff that roll checks should be carried out at the scheduled time, a response should be solicited from the prisoner and officers verifying the roll should only do so when they have completed the check themselves.

Accepted – A Notice to Staff to be published.