Circumstances surrounding the death of a man at hospital in November 2008 whilst in the custody of HMP Belmarsh

Report by the Prisons and Probation Ombudsman for England and Wales

September 2010

The man was found hanging in his single cell at HMP Belmarsh in November 2008.

A self harm monitoring document had been opened for the man during the evening of 17 November but it was closed shortly afterwards as an assessor judged him not to be at risk. He was therefore not subject to formal monitoring, but day staff had asked the night officer to check on him anyway because they remained concerned. The night officer checked him every half hour, and at approximately 1.40am found him hanging.

The night officer called for assistance but did not go into the cell until more staff arrived a few minutes later. They could not find any pulse and started resuscitation. Paramedics were called and were able to clear the man's airways. He was taken to intensive care at hospital, where he died at 5.20pm that day.

The man's next of kin live in India. The prison was able to contact them and obtain the details of close friends in England. Those friends were present when the life support machine was switched off and he passed away. He was 61 years old. My colleagues and I would like to extend our condolences to the man's family and all those affected by his death.

The investigation was carried out on my behalf by my investigator. A review of the man's clinical care was carried out by a team led by a clinical reviewer, on behalf of the local Primary Care Trust (PCT). The review was received by my office on 17 August 2009. My investigator asked for further clarification of some issues, and a response was received on 10 September 2009. The clinical reviewer has forwarded her sincere apologies to the man's family for the delay in completing the clinical review.

I made six recommendations. Four towards the prison with regard to policies and procedures and one to the PCT in partnership with the prison which relates to training. I also made one national recommendation to the National Offender Management Service concerning the procedure for entering a cell during the night. At draft stage all of the recommendations were accepted by NOMS and their response is shown alongside the recommendations at the end of this report.

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

Jane Webb
Acting Prisons and Probation Ombudsman **September 2010**

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SUMMARY

The man was an Indian national. He had been in prison since June 2006 and was serving a life sentence with a 15 year tariff. Initially he was held at HMP Wormwood Scrubs; he then transferred to HMP Belmarsh. He had been at Belmarsh just over a year and a half when he took his own life. He was diabetic and his condition was poorly controlled.

The records show that the man was a difficult person to manage in prison. He was involved in several altercations with cellmates. He was also reported to be abusive to certain prisoners in the food servery and to one of the nurses on the wing. He did not comply with his medication and diet to manage his diabetes. It was the view of some staff that he could not communicate well and his outbursts resulted from frustration. The clinical review panel conclude that he was managed as well as can be expected within the constraints of a patient who was uncooperative with treatment plans.

On four occasions between November 2007 and November 2008, the man was monitored under the Prison Service's suicide and self harm procedures. The reasons varied from his being unable to attend a Sikh service to saying he had issues with his medication and problems with prison 'basics'. He also said in one assessment that he had nothing to live for because of his age and length of sentence. It seemed to the staff that he threatened suicide or self harm in response to not getting something or believing he was not getting something he was entitled to.

The day before he died, the man had an altercation with servery workers. He took all his medication back to the treatment hatch on the wing. It was reported following his death that he had given some of his possessions away to other prisoners. That evening, his friend on the wing raised concerns with staff that the man might take his life that night. An officer opened a suicide monitoring form. A short while later an assessor went to the wing to interview him. It was the assessor's view that the man was not suicidal and he closed the monitoring form without completing the document. This was not the proper process. The officers on the wing remained concerned about him and asked the night duty officer to monitor him.

The night officer on the night of 17/18 November checked regularly during his shift and the man knew he was being monitored. At 1.40am, the night officer looked through the observation panel. He saw him hanging and called for emergency assistance via his radio. The cell door was opened when other officers arrived a few minutes later. The officers who responded carried out cardio pulmonary resuscitation (CPR). Nurses arrived but did not take charge of the resuscitation efforts as they should have. Paramedics and ambulance crews also arrived and they took over from the officers. The man was taken to Intensive Care at hospital. Later that day the prison was able to contact his family in India who provided details of family friends in England. His friends were present at the hospital when his life support machine was switched off. He passed away at 5.20pm.

THE INVESTIGATION PROCESS

1. My office asked for all the relevant prison documents including the man's core prison records, medical file and recordings of monitored telephone conversations. They were received at the end of December 2008. My investigator also visited Belmarsh on several occasions to conduct interviews.

2. Notices to staff and prisoners were sent to the prison to be displayed. They invited anybody with information to talk to my investigators. Apart from those invited for interview by my investigator no other staff or prisoners came forward.

3. A review into the man's clinical care in prison was commissioned and carried out by a panel led by a clinical reviewer on behalf of the local PCT. The review was due by 30 January 2009. However, because of a delay receiving the documentation, the timescale was extended to the middle of March. Subsequent delays followed despite numerous requests by my investigator for information. Although my investigator wrote to the Chief Executive of the PCT, I have still received no explanation as to the reasons. The review was received in my office on 17 August. My investigator wrote back to the clinical reviewer requesting extra information and a response was received on 10 September.

4. HM Coroner for Inner South London District was informed of my investigation. He will receive a copy of this report.

5. The man's next of kin live in India. Two of my Family Liaison Officers (FLOs) have been in contact with the family in India to offer the opportunity to be involved in the investigation. The man's daughter-in-law told one FLO that she had been informed about the investigation by a family friend living in England. The family agreed that he would be the point of contact for the investigation.

6. The man had kept in touch with his family in India quite regularly by letter and phone calls. He last telephoned them ten days before he died (according to the prison telephone record it was on 8 October 2008) and said that he was "fine" and that they were not to worry about him. The next they heard was when the prison telephoned to tell them he had gone to hospital. The family want as much detail as possible about what happened in the intervening period to cause his death. The family received a draft copy of this report and raised no further questions in relation to the findings of the investigation.

7. The family friend arranged for the man's body to be returned to India. The prison initially contributed £3,000 towards the cost as per Prison Service policy. The actual cost was nearly £300 more and, at the family friend's request, the prison reimbursed the extra sum.

8. The family friend later told my FLO that he felt "abandoned" by staff at Belmarsh. My investigator spoke to the prison's own FLOs, both of whom were surprised to hear this. They felt that they had arranged appropriate contact and had offered proper assistance to him. It would appear that there was a genuine misunderstanding about the levels of support and contact that were required and offered.

HMP BELMARSH AND LOCAL POLICY

8. Belmarsh is a local prison within the Prison Service's high security estate. It first became operational on 2 April 1991. The prison's dual role is to serve the Central Criminal Court and Magistrates' Courts in East London and parts of Essex, and to hold high security risk prisoners on remand and awaiting trial. It can take a maximum of 910 prisoners.

9. The accommodation is made up of four residential units and a high security unit, with a mix of multi-occupancy and single cells. There is a healthcare centre that provides primary care services, mental health day care, and outpatient services. There is also an inpatient facility which is mainly used for prisoners with psychiatric problems. There are remedial gym facilities, and other activities include education and workshops.

10. The death of the man was the 15th I have investigated at Belmarsh. There were two other deaths before his in 2008, both due to natural causes. It does not appear there were any similarities with the circumstances of his death.

11. Her Majesty's Chief Inspector of Prisons carried out a full inspection of Belmarsh in October 2007. The Chief Inspector said that Belmarsh had had a succession of poor inspections which reflected a culture focussed on security and insufficiently on safety, decency and the need to reduce re-offending. During the 2007 inspection, the Chief Inspector found that there had been considerable positive change under a new management team and that many areas were showing improvement. However, in the Inspectorate's prisoner survey there were more negative responses from black and minority ethnic minority prisoners (although this is a finding common to many prisons and not solely related to Belmarsh). The full report can be found at www.justice.gov.uk/inspectorates/hmi-prisons.

12. The Chair of the Independent Monitoring Board (IMB) wrote in the foreword of their 2007-2008 report that Belmarsh was a prison:

    > "… continually trying to do its best in difficult circumstances to manage safely the large groups of men held there in custody. It has had to face the challenges of changing demands and expectations both from the general public and from prisoners themselves …"

    The full report can be found at www.imb.gov.uk.

Assessment Care in Custody and Teamwork (ACCT)

13. ACCT is the Prison Service's process for supporting prisoners at risk of harming themselves. The Service's policy (PSO 2700) for suicide and self harm prevention can be found at www.hmprisonservice.gov.uk. Individual prisons have their own local suicide and self harm policies which give instructions about managing the ACCT process. At Belmarsh the guidance is as follows:

Who can open an ACCT?
Any member of staff can open an ACCT.

When will an ACCT be opened?
When a prisoner is identified as being at risk of suicide or self-harm. This includes when feelings of depression are evident and when there are other signs of suicidal tendencies…

How should an ACCT be opened?
The initiating member of staff opening the ACCT must enter the relevant information required on the front cover. They **must** then complete Page 3 (Concern and Keep Safe Form), ticking all the relevant boxes and giving as much detail as possible. If in doubt seek guidance from SPC [Suicide Prevention Co-Ordinator], orderly officer or duty governor. If a prisoner is on ACCT then ensure that this is brought to the attention of the prisoner's unit manager.

A manager of Senior Officer level or above must complete Page 4 (Immediate Action Plan). The manager should talk to the person identified as 'at risk' and spend time listening to the prisoner and explore ideas that he believes could help resolve the situation. They then should decide on immediate action required to keep the prisoner safe, in consultation (where possible) with the person who opened the 'Care and Keep Safe' form and Healthcare staff (this can be done over the phone …)

Immediate action should include decisions about:-

Where the person at risk should be managed
Frequency of Conversations and Observations
Initial Action staff need to take to support the person-at-risk

First Case Review
A case review will be held, ideally immediately after the Assessment Interview, attended by the prisoner, Assessor, Residential manager and other appropriate staff and chaired by the residential case manager. The case review must take place within 24 hours of the concern being raised …

Estimate the level of the prisoner's risk as low, raised or high. This is a joint decision made by the case review team on the basis of all the information available to them. Including but not solely the information from the assessment interview.

Decide if the ACCT Plan needs to be continued or closed.

Making the decision about level of risk
The responsibility for deciding on level of risk and action rests with the group of people who make up the first and subsequent case reviews – that is the responsibility rests with the team – not with the ACCT assessor as an individual.

Where a prisoner-at-risk is present at case reviews, it is inevitable that sometimes the staff present and the prisoner may disagree about level of risk and what actions to take. For example, staff may be concerned that the prisoner may harm himself and the prisoner asks to be left alone. Involving and listening to the prisoner-at-risk in case reviews does not necessarily mean that staff have to agree to what they ask for. Where disagreement occurs, it is important to:

- Acknowledge that you have heard what the individual has told you and also to
- Explain why you are still concerned despite what they are telling you.

… the decision to close an ACCT plan should be made on the basis of all the information available to the Case Review Team, including but not exclusively, the expressed thoughts and feelings of the person at risk. For example, there have been cases where those in the early period of custody, on remand for murder of a family member, have displayed calm and reported no suicidal intentions but have then killed themselves.

Deciding on closure with the person-at-risk

Staff may not be familiar with discussing whether or not the level of risk has dropped sufficiently for it to be safe to close an ACCT Plan in the presence of the person at risk.

It is important to be aware that involving the person at risk in this discussion is not the same as necessarily agreeing with what he says or doing what they want to be done.

In most cases, the best source of information about whether or not the person is still intending to kill themselves is the person themselves. However, in some cases, it may be that staff believe that the person is self-harming and at risk of suicide, even when he claims that this is not the case. Where this occurs, it is still important to:

> Acknowledge that you have heard what the individual has told you and also to explain why you are still concerned despite what they are telling you.

The decision to close an ACCT plan needs to be taken by the Case Review team as a whole, using all the information available to it – including what the person at risk has to say …

20. The examples in the guidance for closing an ACCT are more applicable to an ACCT which has been open for a longer period that of the man and one where action plans are in place. The guidance does reiterate however, that the ACCT should be closed at a case review.

21. There is also guidance on re-opening an ACCT document. This refers to the document being reopened if a prisoner carries out an act of self harm or threatens to do so. It says that, in these instances, if an ACCT document has

been recently closed it can be re-opened. There is no need to open a new ACCT form. A new Case Review must take place within 24 hours and this will negate the need for a new assessment. However, there is no specific guidance for opening an ACCT if staff still have concerns but no act or threat has been carried out, although it would be logical to assume that the same should apply.

22. So far as the ACCT assessor team is concerned, the key areas of Belmarsh's policy in relation to the man's death are as follows:

    - There is a system of on-going support to the assessor team in place.

    - It is good practice for ACCT assessors, wherever possible, to arrange their assessment interview at a time that means that the residential manager can be present immediately afterwards, so that the first case review can take place straightaway and there can be good communication between the assessor and the case manager and other staff.

KEY FINDINGS

23. The man was remanded into custody at HMP Wormwood Scrubs on 7 June 2006. He underwent a health screen on his arrival. The clinical review panel notes that the medical record showed a history of asthma, diabetes and painful joints. There was no recorded evidence of mental health illness or substance misuse. During his time at Wormwood Scrubs, his wing history shows that he was quite demanding about sharing cells. It appears that he had regular altercations with his cellmates and anti-bullying procedures were put in place as a means of monitoring his behaviour. He was located on the first floor because he suffered from asthma. His records do not give much more information about the period he spent at Wormwood Scrubs.

24. On 2 March 2007, the man transferred to HMP Belmarsh. At times he would appear to be settled and have no problems, but predominantly he came to the attention of officers because of negative behaviour. This ranged from poor hygiene or not following instructions to being surly with staff and other prisoners. It was noted that he did not speak English very well and staff sometimes asked other prisoners who spoke his language to help him. In interviews following his death, staff said they had the impression that he could understand more than he could speak, but also that he could speak more than he would have them believe.

25. On 8 November 2007, the man's cellmate committed suicide by hanging. He was not in the cell at the time but was just returning with an officer . As the officer opened the door, he saw the man's cellmate hanging. He pushed the man away and called for assistance. Arrangements were in place to move him into a cell with somebody who spoke Punjabi. However, whether this actually happened is not recorded. On 13 November, the man spoke to the Sikh Minister about his cellmate. He also said he was having problems with his tobacco and pin numbers (used for making telephone calls), and that he had stopped taking his diabetic medication as a protest and might also stop eating or hang himself. The Sikh Minister opened an ACCT document. The record shows that the man told him he was 61 years old and had a 15 year tariff for an offence he said he had committed in self defence. He added that he had nothing to look forward to and that if he "did not get the basics in prison there was no point living".

26. In the ACCT assessment interview which followed, the man told the assessor that his three problems were:

    - "long sentence, can't get to India to see grandchildren
      does not like people being rude to him, this causes a lot of distress [this is not explained further]
    - guilt of offence, due to him believing it was self-defence".

    One of the follow up actions in the ACCT was to ensure that the man's diabetic medication was taken as appropriate. At the ACCT case review on 18 November, it was noted that he still refused to take his diabetes medication and his blood sugar was high as a result. The reason for his protest was recorded

as an issue with clothing, although he had been given the clothing that was in his property. He refused to attend the ACCT review. (It would appear that his clothes had been removed after the death of his cellmate. This is standard procedure in case they are required for forensic evidence.)

27. Another case review was held on 25 November. The man continued to refuse his medication with the exception of his inhaler. His refusal was still in protest about his clothing not being returned. It was noted that he was eating and drinking well. However, in the following case review on 2 December he told staff he was now not eating because his choices[1] were wrong, but added that he would be dead in two weeks if he did not get his clothes back. The ACCT document was closed the next day after another case review. At that review, he told staff he was "not suicidal" and asked them if they "thought he was stupid". He told them he had grandchildren he wanted to see and would not contemplate any thoughts of suicide. He said that, when the issue relating to his clothes was resolved, he would start taking his medication. (He later submitted a complaint form for the missing clothes and was given compensation by the prison.)

28. The next few months passed in much the same way. The man continued to have issues with his cellmates and, on one occasion, refused to share with a black prisoner. As part of his sentence progression, he transferred to HMP Whitemoor on 1 May 2008. The next day he was returned to Belmarsh. My investigator could not find any written explanation why he was returned, but in interview the Principal Officer (PO) said that it was because the man had refused his medication on arrival at Whitemoor.

29. Two more altercations with cellmates took place in May and staff took the decision to mark the man's cell sharing risk assessment up to a 'High Risk' to others. He was given a single cell. Staff interviewed by my investigator were of the impression that he had difficulty communicating and became frustrated and angry when he could not get what he wanted. It is possible this might have been a factor in the arguments he had with cellmates.

30. The man was returned to his cell during association time on 3 September 2008 after being aggressive and abusive towards one of the houseblock nurses and throwing his medication on the floor. This behaviour was repeated several times in the period between then and his death. During the morning of 30 September, he was returned to the wing from education because he was not following instructions and only doing the work he wanted. He said it was because he was unwell and therefore returned to his cell.

31. Later that afternoon, at approximately 2.30pm, the man pressed his cell bell. Officers responded and found that he had tied shoelaces around his neck and to the window bars and was standing on a chair. He was cut down and assessed by a nurse. No injuries were reported but his medication was taken

[1] Prisoners are given a variety of meals to choose from. Those on special diets such as diabetic diets can plan their meals accordingly.

out of his possession, with the exception of his inhalers. A new ACCT was opened.

32. The man told the staff that he was feeling low because he had been unable to attend the Sikh service that day. There appears to have been a mix up with the allocations list and his name had not been included. The following day during the ACCT assessment interview, he said he felt he was being bullied by staff and other prisoners (there is no further explanation of this) but that he did feel better being on the new houseblock.[2] He told the assessors that the incident the previous day was not an attempt at suicide; he had just wanted to go to the Sikh service. The interview records that he said it was not "a lethal attempt as he was stood on his chair" and adds "he doesn't want to be dead". A governor who speaks the same language as the man attended the case review soon after the assessment. At the review, the man repeated that he had no thoughts of self harm. The ACCT was closed as a result. Measures were put in place to ensure that his name was on the list for the Sikh services.

33. During October, the wing history sheet shows more of the same behaviour. Although the man was polite at times, he would lose his temper for no apparent reason. He remained as high risk for cell sharing. On one occasion he threw his diabetic food pack back at the food servery. This behaviour occurred several times over the next month. He also had several outbursts at the nurse on the houseblock and would throw his medication back at her.

34. There is a note in the man's medical record of an appointment with a doctor on 3 November. It appears to be an entry by a prison doctor, but the signature is illegible. Although difficult to read, it would appear that he spoke to the doctor about the conflict he had with a houseblock nurse (no name is mentioned but it seems to refer to a nurse) and not taking his medication. The doctor wrote that the man had no self harm or suicide issues. He also recorded that there was no evidence of mental illness. He decided that the man should collect a weekly supply of his medication and assessed that, in all other respects, he appeared well and there were no other concerns.

35. After returning from the medication hatch on 4 November, the man told an officer that he was going to hang himself because of issues over his medication and with the houseblock nurse, now named as "the nurse". Another ACCT document was opened. At interview, the officer said that the man had made a gesture with his finger as if he was cutting his throat, and that this was why she had opened an ACCT.

36. An officer on Houseblock 2, who was also an ACCT assessor, carried out the ACCT assessment approximately half an hour after the ACCT was opened. The man said he had no thoughts of suicide just that every time "he sees that nurse there is a problem". It was agreed that the man would discuss his medication with a doctor – although according to the medical record this had

[2] The man moved houseblocks and cells on numerous occasions at Belmarsh. The data showing his moves is difficult to decipher and confirm and so individual changes of location are not noted in this report.

happened the previous day. There also appeared to be a problem with his pin numbers although this was not explained further.

37. There is an entry in the ACCT document on 4 November at 7.30pm in what appears to be the same handwriting as the medical record on 3 November and which the clinical review panel confirm was made by the prison doctor. He notes that he was asked to assess "cell share etc." A history of self harm is noted as well as the conflict over the man's medication. Again it is said that this should be collected on a weekly basis. The findings of no mental illness and no suicidal intentions or ideas were repeated. (It is not clear whether these were two separate consultations with the doctor or if the date in the medical record is incorrect.)

38. The following day (5 November 2008), the man reiterated at the case review that he had no intentions of self harm or suicide. The ACCT was closed.

39. The wing history sheet shows that the issues regarding medication and pin numbers were resolved on 8 November although again the specifics are not recorded. Three days later, on 11 November, there is another entry recording that the man had been abusive to the houseblock nurse and thrown his medication on the landing. There is no record of this in the medical notes.

40. On 15 November, the man made a telephone call to a friend. This was the fourth call he had made to the same friend in a month. During this conversation, he told his friend about a man he had met who had a very good lawyer. He told his friend that the man said the lawyer would visit him the following week and help him re-open the case. He said that there would then be a re-trial. He added that, if there was a retrial, he would be out of prison in a year's time.

41. During the evening meal time on 17 November, at approximately 6.30pm, the man threw his food at the servery workers. He was warned by a Senior Officer (SO) that his behaviour would not be tolerated. The record shows that he said he would do it again if he did not get the meal and provisions that he wanted. The SO told him that if such behaviour was repeated he would be segregated. At around the same time, the man returned all his medication to the treatment hatch where a nurse was on duty. The nurse is a Registered General (RGN) and Mental Health Nurse (RMN). She wrote in the medical record that she had spoken to an officer, although a name is not given, who had told her about the man's behaviour at the servery. (The nurse was not interviewed by the clinical review panel as they judged her documentary evidence was sufficient.)

42. During association between 7.00pm and 7.30pm, another prisoner and friend of the man's approached an officer. In her statement, the officer said that the prisoner told her he was worried about the man. She said that he believed the man would try to kill himself that night and that he had never seen him in the state he was in. He asked staff to remove any razor blades from the man's cell. He said he told the man that any problems could be dealt with at the Sikh service the following day. The man is reported to have replied, "There is no tomorrow for me."

43. The officer went to speak to the SO on duty about her conversation with the prisoner. The SO advised her to open an ACCT. She did this at approximately 7.30pm but she did not speak to the man. In the meantime, the SO arranged for the duty ACCT assessor to carry out the assessment interview. At interview, the SO said that he and a nurse had a conversation with the man. He said that the man talked about his diabetes and that it was not a problem any more. He was no longer worried about his food either. He said that arrangements were in place for him to move to the healthcare centre overnight. He did not record any of this in the ACCT document, but the nurse made the following entry in the medical record noted at 8.00pm:

> "Spoke to the man in the treatment room he informed me that he wants diabetic food, he doesn't like the food that's being served. Advised him that diabetics can eat any foods apart from anything with sugar but he turned around and said he did not like potatoes, rice, carrots and most of the food. Apparently he spoke to one of the inmates that they [sic] is no tomorrow for him. Spoke to healthcare decided that he stays in healthcare overnight for observation then be assessed by psychiatrist in the morning."

44. A second PO was the orderly officer in charge of the prison (Oscar 1) at this time. In interview, she said that she had been told staff had opened an ACCT on the man and they were waiting for an assessment. She was told that there was a space in healthcare and she arranged for staff to be available to facilitate his move there from the wing. Because of the time of night, she handed over to the first PO, the night orderly officer in charge of the prison, and then went off duty. Her understanding when she left the prison was that the man would move to healthcare.

45. The assessor, who had carried out a previous assessment on the man in November 2007, was the duty ACCT assessor on 17 November. He was working on a different houseblock and went to Houseblock 2 once association was finished. The timings given by staff vary but it was between 7.50pm and 8.15pm. At interview, he said that, before carrying out the assessment, he did not know of the man's recent self harm attempts. He said he was also unaware of the altercations at the servery and medical hatch or that the man had been giving possessions away. (Following the man's death it was rumoured that he had given some possessions away. There are no confirmed details of this in the documentary evidence.)

46. The SO said during interview, "About 7.55 he [the assessor] came over, I gave him a briefing as to what we'd seen from the man during the course of the day, the evening, what he'd said…" The SO told the assessor that a place had been made available for the man in healthcare and that staff had been arranged to take him there after the assessment. The assessor went to the man's cell with another officer, a third officer. (At the time, this officer had been a qualified prison officer for approximately three weeks.)

47. In his statement, the assessor said that the man invited him to sit on his bed. When he told him why he was there, the man looked shocked and told him he

had no intention of taking his own life. He showed the assessor photographs of his grandchildren and told him they were the reason he wanted to live. The officer reports that the man was in a good mood, laughing at the proposal that he was suicidal and appeared "very calm and rational, even relaxed". The assessor wrote in his statement that:

> "… on this information and my experience I decided that the ACCT Plan was to be closed. I made the decision that there was insufficient evidence to warrant carrying out a full assessment. I am a trained ACCT assessor with a lot of experience in dealing with prisoners in crisis; I believed that the man wasn't a threat to himself due to the information he was giving me at the time of speaking to him."

48. At interview, the third officer told my investigator that he did not speak to the man. He said he was asked to go with the assessor because the prisoners had been locked in their cells for the night and the prison's procedure called for two officers to be present to unlock the cell. The officer said that the man was incoherent and that he could not understand what he was saying. He remembered him getting some photographs of children and saying "no, no" whilst pointing at them. He added that he did not know who the children in the photographs were or what he was referring to. The assessor reiterated at his interview that they were photographs of the man's grandchildren, and that he had said that he had them to live for so he was not going to take his own life. He said that he had had previous contact with the man and was therefore able to understand what he was saying.

49. The two officers returned to the centre office. The first two officers and a fourth officer were in the office. The assessor told the others that he was closing the ACCT form. The details of who said what to whom next are somewhat cloudy, but in interview one of the officers said they told the assessor that the man had recently been on an ACCT.

50. In the first officer's written statement she reported that the assessor said that the man had told him that "he was not suicidal and never has been". She wrote further that, after saying he would close the ACCT, the assessor was told by the second officer that the man had tried to hang himself approximately three weeks previously. The first officer also wrote that the assessor told them that the man was laughing and joking with him. She added that she and the other two officers felt that this was unusual behaviour for him and told the assessor so. She added that the third officer told them that the man had shown the photos of some children and had said that he would not do anything because of them. She said in her statement that she and the other officers expressed concern that his ACCT had been closed because they were worried about his welfare.

51. In his interview, the assessor said that he was unaware of the man's recent ACCT document and of all the events of that day until after his death. He said:

> "I wasn't told any other information about anything happened during the day all I was told, an assessment needs to be done and I needed to go and do

it. I sat down on the man's bed, introduced myself, we shook hands and the third officer was standing by the wall. I said to the man, I said there's been information received that you are going to kill yourself tonight, can you, you know explain what's going on. He looked shocked, he laughed off the allegation. He says I'm not going to kill myself and he went to his cupboard and he got all his pictures out of his grandchildren, he said I've got this to live for I'm not going to kill myself at all. So I asked him again are you sure you are not going to do nothing silly tonight. I said because, he showed no signs of suicide, no signs of any issues at all. He was very happy, laughing, joking and I had no reason to believe that he was going to kill himself. So I come downstairs, the staff were pressurising me into doing something so I couldn't see any symptoms or any reason why he should be on an ACCT plan - because apparently three weeks previous to that he tried to hang himself but the ACCT plan was closed for some unknown reason which is very strange. If a person does that then you need to leave him on the ACCT plan for more than what they left him on for. I would personally but I could see no reason for him to be on an ACCT plan, I had no reason to disbelieve the prisoner at all so I closed the ACCT and I didn't realise at the time that the SO wasn't there. I thought the SO would have stayed behind waiting for me to come downstairs then we could have discussed the information I'd discovered and then go from there. But I found out he'd left the houseblock to go and sign the prison roll which to me seemed very strange."

52. My investigator asked the assessor what he meant by staff pressurising him to do something. He said "…if the staff think he's mad, that doesn't warrant a prisoner being on an ACCT plan". My investigator asked what the other staff said when he told them he had closed the ACCT. He replied:

    "I can remember one person saying that he's mad. I said well that doesn't warrant him being on an ACCT plan first all. The young lady who just left, [referring to the first officer who had just been interviewed by my investigator] I spoke to her and she seemed fine. She was fine about it that the ACCT plan had been closed and he had no signs, I didn't think he had any symptoms at all for committing suicide."

53. In interview, the second officer told my investigator that he would not close an ACCT, but his view was that the officer was an ACCT assessor, an ACCT trainer and, he thought at the time, a senior officer. He said that he (the second officer) was not present when the decision was made and does not remember being involved in a discussion about the man's normal behaviour. He said he would not want to question a colleague who was a trainer in the subject. He added that in hindsight he wished that he had challenged the assessor's decision. However, he had briefed the night staff to "keep an eye" on the man. After reading and signing his transcript, the second officer has added that he told the assessor that a safe cell was available in healthcare. (I understand from evidence in other interviews that the safe cell was actually on a different wing rather than in healthcare.) At draft consultation stage Belmarsh said that a request was made for healthcare services to prepare a bed on the inpatient unit to transfer the man from the houseblock. Arrangements were made for this but

he was not transferred and no contact was made with the inpatient team who were on duty that night.

54. The fourth officer told my investigator in his interview that he remembered telling the assessor about the man's previous ACCT following his missing the Sikh service. He had not been aware of any previous attempts at suicide. He could not confirm whether he told the assessor that the man had returned all his medication to the nurse or that he had had problems at the servery earlier in the day. He also said that he spoke to the night officer about keeping an eye on him.

55. When the night duty officer came on duty he was told by the SO that an ACCT had been opened on the man. They were waiting for an ACCT assessment and he would move to healthcare. The night officer went around the houseblock to ensure that all the doors were locked. When he returned to the centre office, the first, second and fourth officers told him that the man's ACCT was being closed but they asked him to monitor him through the night nonetheless. The night officer said in interview that he did not know why the ACCT had been closed, but he had agreed to check him through the night.

56. At his interview, the night officer said that he checked the man at least five times before he started pegging[3] at 10.00pm. He then checked him approximately every half hour when he pegged. He did not make a record of the checks but there was no requirement to do so. He said that he would look through the man's observation panel. The man asked him what he was doing a couple of times; he also spoke in what the officer thought might have been his native tongue. The night officer then walked away and looked through the other panel near the toilet area so that the man could not see him watching. He said he did this so that he could watch the man unobserved and make sure that he was not harming himself.

57. Between 1.37am and 1.40am, the night officer completed his pegging and checked the man again. He looked through the cell observation panel and saw him hanging from the window bars. He used his radio to call for emergency assistance. He did not go into the cell on his own. My investigator asked why he waited when he had a cell key which he could access in emergencies (officers do not carry a full set of keys on night duty). He explained that he wanted assistance because he knew that one person had to hold the man's weight while another cut him down. He did not want to cut the ligature and let him fall or cause any further damage.

58. The Night Orderly Officer, the PO (Oscar 1), arrived within a few minutes along with two other night staff. The three members of staff went into the cell. A fifth officer supported the man's weight while the sixth officer cut the ligature. They put him into the recovery position but could not get any reaction from him or find a pulse. They began cardiopulmonary resuscitation (CPR). Whilst the

[3] Pegging is an expression used by the Prison Service to describe a security procedure for accounting that an area has been visited by an officer. The system records the date and time, and can be monitored as necessary.

officers went to the houseblock, a second SO (Oscar 2) ran to healthcare to get the nurses. (During night state, nurses like uniformed staff do not carry a full set of keys. The nurses need to wait until they are collected by a member of staff with keys.)

59. The fifth officer tried to clear the man's airway and give breaths while the sixth officer carried out chest compressions. The PO called for an ambulance at approximately 1.48am. My investigator asked why an ambulance was not called immediately. He said that there was so much going on and they were trying to stabilise the man. A defibrillator[4] was requested which the PO sent the night officer to collect. However, he returned with a first aid kit rather than the defibrillator.

60. As this was happening, the nurses arrived at the cell. They had their 'grab bags' with them which contained emergency medical equipment (although it appears that they did not use any.) The nurse also asked for the defibrillator and the PO went to get one from the SO's office. It is unclear from any of the statements who actually applied the defibrillator, but it is known that it was used. It did not advise that electric shocks should be given and so CPR was continued by the officers. The nurses did not take charge or take over resuscitation efforts from the officers. At draft consultation stage Belmarsh felt that it was relevant to add that the sixth officer "had recently transferred over from healthcare after many years service and that he was fully trained and highly competent in medical response techniques and in particular, CPR. He was well known to the nurse and she had every confidence in his ability".

61. The second SO had escorted the nurses through to the wing. He saw the night officer and was concerned that he looked distressed. He knew that the nurses and three of his colleagues were with the man so he stopped to ensure that the night officer was alright. After checking him, he went into the cell. He took over CPR from the fifth officer who went to meet the ambulance at the gate. A paramedic first response arrived at the gate at 1.56am and an ambulance at 2.01am.

62. The paramedics and ambulance crew took over the resuscitation attempts from the officers. By clearing some vomit and inserting a tube they managed to administer breaths more effectively and identified a weak pulse. The man was put in the ambulance and taken to Intensive Care at hospital at approximately 2.55am.

Events following the man's transfer to hospital

63. The fifth and sixth officers went to the hospital with the man. They remained until they were relieved at 7.00am by day staff. Both officers then had to return to the prison to complete the necessary paperwork and attend an initial debrief meeting.

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[4] A defibrillator can restart the heart in some cases of cardiac arrest by giving an electric shock. It detects the electrical activity in the heart and gives automated instructions to the rescuer.

64. The man's family live in India. One of the governors who, as noted above, speaks Punjabi, tried to find details of his family or friends. At approximately 10.30am, after obtaining the number of the man's family in India, he telephoned the man's son. He initially spoke to the man's daughter-in-law who had never met the man. The governor then spoke to the man's son. He was worried about his father and gave details of close family friends in England.

65. The governor then telephoned the man's family friends. It was agreed between all parties that they would act as the next of kin. He passed on the hospital details so that they could visit him. Doctors at the hospital took brain stem tests. The man's condition did not improve. His family friends were present at approximately 5.00pm when his life support was switched off. At 5.20pm, he was pronounced dead.

The debrief

66. At the debrief earlier that morning, officers raised concerns that the nurses had not taken over and helped them when they arrived at the man's cell. The clinical review panel has commented that the nurses involved in the emergency response were not included in the debrief. The panel also say that the Head of Healthcare had raised this with the Governor. The Head of Healthcare had also made numerous requests to another governor grade for a full debrief but, at the time the clinical review was completed, it had still not taken place.

67. The person who was a residential governor at the time of the man's death but who has since moved to a different prison, wrote to the Governor regarding the concerns raised by discipline staff about the lack of nursing intervention. The Head of Healthcare was not copied in as Head of Healthcare. The former residential governor wrote:

    - "Nursing staff appeared unsure of their role in a medical emergency of this nature and in particular the need to take control of the incident and use medical interventions to assist.
    - Nursing staff appeared unaware of their need to use the equipment contained in the medical response bag and consensus is that this bag was not actually opened.
    - Oxygen was not used prior to the arrival of the LAS [London Ambulance Service] by medical staff.
    - A Bag Valve Mask (BVM) was not used prior to the arrival of the LAS by medical staff.
    - Oral Airways were not used prior to the arrival of the LAS by medical staff."

68. The clinical review panel comment that the officers remained in charge of the situation at the man's cell. The panel has said that the nurse told them that she was unaware of any concerns being raised about the nursing intervention, or lack of it, at the time. The panel go on to say that they found, during their interviews with healthcare staff, that the nurses had offered to take over CPR but the officers replied that they were happy to continue.

69. The Head of Healthcare interviewed the nurse on 5 December to discuss the emergency response and wrote to the Governor with his findings. He found that the nurse had

> "… assessed the man's condition and satisfied herself that immediate first aid/CPR was being appropriately administered. She was also aware that an emergency ambulance had been called to take him to hospital."

He asked the nurse if she had considered oxygen therapy. He wrote that the nurse had not considered it appropriate at the time. She added that the man was not breathing independently and she thought it was more efficient to continue CPR to maintain the circulation of oxygen.

70. The Head of Healthcare confirmed in his letter to the Governor that there were no immediate issues of safety relating to the clinical competence of the nurse. However, he did have concerns "… regarding the role of the nurse attending a medical emergency; the lack of assertiveness, poor communication and effective decision making". She had agreed that she remained on the periphery because she was satisfied that the response was being managed appropriately. The nurse added that she had offered to relieve the officers carrying out CPR. She was of the view that the man had died prior to the resuscitation attempts.

Additional information received

71. My investigator asked the prison if there was any information about bullying, other than that of which the man had been accused. The prison liaison officer made enquiries and an officer from Houseblock 2 was able to provide some details. He had not initially been identified for interview, but when the information regarding bullying came to light he kindly agreed to speak to my investigator at short notice.

72. The officer said he had known the man for a few years. He also has an Indian background, although is not a Sikh, and he believed that the man developed a good rapport with him as a result. He was involved in the emergency response when the man's previous cellmate was found hanging, and he said that the man would talk to him about it.

73. The man told the officer that he was not getting the extra food he needed at the servery. Two of the servery workers would make fun of his accent and throw food at him. The officer said the man added that if they did not stop "one of them would die or he would." The officer who supervised the servery said that he only witnessed one altercation which was a few weeks before the man's death. He told the man he would deal with the issue and that he should not get involved. He advised him to use the anti-bullying procedure but he did not want to do so.

74. The officer gave the servery workers a verbal warning. They told him that the man was impolite and demanding. He told my investigator that one of the servery workers was demoted and arrangements made for them to be moved from their jobs. My investigator asked why none of this was written in the wing history sheet. He thought that he had written it. He said he had not used the official procedure because the man had not wanted to and he did not want him to lose faith in him. He also felt that matters might have escalated if ‘groups’ started forming within the wing and took sides. However, he had spoken about the matter with the Assistant Race Relations Officer. The Assistant Race Relations Officer confirmed this, but told my investigator that he could not take the matter further without formal paperwork. He added that prisoners could submit ‘request and complaint’ forms if they had any concerns.

ISSUES CONSIDERED

Assessment, Care in Custody and Teamwork (ACCT) document of 17 November 2008

75. The man had been on several ACCTs whilst he was at Belmarsh. On 17 November 2008, his friend was sufficiently worried to raise his concerns with staff and an ACCT was opened. He had allegedly given some of his possessions away and returned his medication to the nurse. Both behaviours can be associated with suicidal thoughts, but the link does not appear to have been made by wing staff or the ACCT assessor. This may be because not all the information was known by them until after his death.

76. The ACCT was opened by the firs tofficer who regularly worked on Houseblock 2 and knew the man. She approached the SO for advice as to what she should do next. He advised her to open an ACCT form and then took it upon himself to contact healthcare to discuss the situation and to take matters forward from there. Ideally, she should also have spoken with the man directly before writing in the ACCT document.

77. The assessor was the duty assessor on 17 November. He went to speak to the man and decided that it was not necessary for him to be on an ACCT and hence closed it. Subsequent objections were made to the assessor, but he believed that there was no need for the ACCT to be open and did not fill out the documentation. It is of evident concern that he should have commented in interview that "if a prisoner says he is not going to commit suicide you've got to take his word for it". With his experience and training he should know that this is not true. In any event, the correct procedure for closing an ACCT was not followed. At the very least the ACCT should have been closed following a case review and the decision made by more than one person. As an assessor and trainer of trainers for ACCT, he should have known this.

78. The ACCT policy allows up to 24 hours for the assessment and case review to take place. It also states that it is good practice to arrange the assessment so that the residential manager can be present immediately afterwards and the first case review can take place. The assessor said that the SO was not on the houseblock after he had completed the assessment. The SO had made provisional arrangements for the man to be assessed and moved to healthcare – although this too was not written on the ACCT document. However, he did not return to the wing to find out what the outcome of the assessment was. The assessor did not seek him out either. During interview, the SO said that he assumed the man would be moved to healthcare as soon as the assessment had been carried out, and left the prison thinking that this would happen.

79. Several of the houseblock officers, including the second officer, who is an ACCT assessor, said that they were not in agreement that the ACCT should have been closed by the assessor. Although they did well to ensure that the information was handed over to the night officer so that checks could be made on the man, they had other options open to them. The ACCT could have been

re-opened and/or they could have taken the matter to a more senior member of staff.

80. The second PO said she did not know the ACCT had been closed when she went off duty. As far as she was aware she had organised staff to be able to move the man to healthcare if necessary. The assessor said at interview that he told the second PO he had closed the ACCT. The first PO, who took over from the second PO, said that he was told that there might be a need to move a prisoner on an open ACCT but was later told it was not an issue. He could not remember who had told him.

81. It would appear that these communication failures may have resulted because they took place just as the shifts were changing and staff were handing over. It may also be that this was the reason that a trained ACCT assessor who knew the man and was on the same wing was not chosen to carry out the assessment, instead of the duty assessor. Some day staff believed that matters were being dealt with. Night staff did not realise the full extent of what should be followed up as they had not been involved from the beginning.

82. As the ACCT was closed prematurely, it is not possible to know what observations the man would have been on. There were clearly plans in place to move him to healthcare for overnight observations. Because houseblock staff told the night officer about his risk, he was in fact monitored every half hour. This may very well have exceeded what the ACCT would have required, and the night officer should be commended for his extra vigilance.

83. Nonetheless, while it would be unjust to apportion blame to any one individual, there were systematic failures that should be addressed to avoid such circumstances recurring.

The Governor should ensure that information regarding prisoners on ACCT is communicated effectively at every handover between staff.

The Governor should incorporate the findings of this report into the ACCT training package for staff.

84. In interview, the assessor spoke candidly about his personal suitability to be an ACCT assessor. He told my investigator that a health assessment after a period of sick absence had resulted in a recommendation that he should not carry out ACCT assessor duties. My investigator was unable to obtain confirmation from any other source that this had been agreed.

85. The Governor of Belmarsh has conducted his own enquiry into the assessor's actions and the officer is facing disciplinary charges. Whatever the outcome, I do not believe he should remain an ACCT assessor until such time as he is deemed medically fit to do so.

Emergency response

86. The night officer found the man during his regular checks, but did not go into the cell when he saw him hanging. This was in line with usual practice that a member of staff should not unlock a cell on their own during the night for evident reasons of security and safety. The man was in a single cell because he was assessed as a high risk to other prisoners and this would have been a legitimate reason for the night officer to wait until he had other officers present. He has also said that he was afraid he would cause more harm than good. However, in the event of an emergency, Belmarsh's local policy does allow for a singleton member of staff to unlock a cell if help has been called and the member of staff is "100% certain that a life could be saved".

87. The local policy which requires "100%" certainty that a life can be saved is probably ill-drafted. However, the issue of entering cells during the night is something that is raised in many of my reports, often because of the lack of clarity in the policy. I therefore recommend that NOMS considers issuing renewed guidance on the issue of entering cells in an emergency, particularly during the night. This should advise when a singleton member of staff should go into a cell in an emergency and when it would be more appropriate to await the arrival of other staff.

    I recommend that NOMS considers issuing renewed guidance to provide clarity about when staff should enter a cell during night state.

88. There are conflicting accounts about how the nursing staff responded when they arrived at the man's cell. The clinical review panel also found that the evidence from the London Ambulance Service (LAS) was unclear. At the debrief, which took place without any nurses present, concerns were raised by officers about the healthcare involvement during the emergency response. The nurses say that they provided incident statements following the response, but they were not with the documentation passed to my investigator. The nurses therefore supplied extra statements early in 2009 at my investigator's request. These were also forwarded to the clinical review panel. In these statements the nurses say that they were involved during the response at the man's cell. This is at odds with the officers' view and the information provided to the Head of Healthcare.

89. During his own enquiries, the Head of Healthcare determined that the nurse had:

    > "… assessed the man's condition and satisfied herself that immediate first aid/CPR was being appropriately administered. She was also aware that an emergency ambulance had been called to take him to hospital."

    He wrote to the Governor with his findings, and confirmed in his letter that there were no immediate issues of safety relating to the clinical competence of the nurse. However, he did have concerns "regarding the role of the nurse attending a medical emergency; the lack of assertiveness, poor communication and effective decision making".

90. The clinical review panel has made a recommendation regarding the internal investigation following the man's death. They have not been specific about their concerns nor given any further explanation for the recommendation. I therefore refer the matter to the PCT to progress and suggest that they feedback through the prison health partnership board.

91. During the course of their review, the clinical review panel found that CPR training for staff was on a three yearly basis. This affected both nurses who responded to the man, and is not in line with professional and NHS requirements for an annual update. In his letter to the Governor, the former residential governor suggested that healthcare managers conduct a skills audit to ensure that staff are competent to use emergency response equipment. He also suggested that healthcare staff receive annual "medical incident management" training. Those staff not already trained or confident in the use of emergency medical equipment should be given the appropriate skills to do so. The clinical review team have endorsed those recommendations.

92. As I have mentioned, much of the evidence regarding the emergency response is contradictory. The nurse told the Head of Healthcare that she remained on the periphery because she was satisfied that the response was being managed appropriately. She believed that the man's condition was very poor and that he had died prior to the attempts to resuscitate. He explained to her that remaining on the periphery can affect other staff who gain confidence when medical staff take control. He is satisfied that she did not fail in her duty of care. I endorse the clinical review's recommendation that medical incident management is reviewed and all staff who might respond to an emergency receive annual refresher healthcare training.

93. I am pleased to note however, that some action has already been taken regarding emergency response training and all registered nurses are required to complete an Advanced Life Skills course including an annual assessment.

The Head of Healthcare in conjunction with the PCT should ensure that all relevant staff are trained in emergency response management and receive annual refresher training. The Head of Healthcare should audit this annually.

94. Healthcare staff were not present at the debrief following the man's transfer to hospital. There were also no written incident statements from either nurse who was present during the emergency response. My investigator was told that these statements had been lost and she received new healthcare statements some months later.

The Governor should ensure that death in custody contingency plans are carried out accurately and that all staff are invited to attend the debrief and provide statements.

Bullying

95. There is some suggestion that the man was being bullied. This relates particularly to the servery workers. It is difficult to determine if this was actually the case as there is also evidence to suggest that it was he who was belligerent at the servery (and medical hatch). From the officer's evidence, it does appear that some servery workers were hostile and possibly racist to the man.

96. I am pleased to record that the officer challenged the servery workers about their behaviour. However, he did not take formal steps as per the prison's anti-bullying policy. At the very least, I would have expected entries to have been made in wing history sheets to alert staff to potential problems. I might also have expected a Racist Incident Report Form (RIRF) to have been raised. This could have set out that the man did not want to take the matter further but would have shared with staff that there was a need to be vigilant.

The Governor should note the issues regarding bullying and remind staff to follow the local procedures.

Healthcare

97. The man was a non-insulin diabetic. He also suffered from asthma and painful joints. An appropriate diet and medication regime were important aspects of his care. However, there were several occasions when he threw his food at the servery workers and his medication at the nurses. He appears to have taken specific exception to the nurse who was the regular houseblock nurse.

98. None of the officers interviewed knew specifically what caused the man to object to his medication. The clinical review has not covered this either. It is possible that his "issue" was not with the nurse personally, but resulted from the fact that she was the nurse most often working on the houseblock.

99. The clinical review panel has commented that, in their view, the man was "managed as well as can be expected within the constraints of a patient who was not cooperative with treatment regimes". The panel conclude that his clinical care at Belmarsh was comparable with that he could have expected to receive in the community.

100. That said, the panel has found that the clinical records did not meet normal acceptable standards. Some of the handwriting and signatures were illegible. My investigator also noted that some of the healthcare contact with the man was not recorded in his medical notes. I endorse the recommendation made by the clinical review panel to introduce a computer based medical record system at Belmarsh. I will refer this separately to the PCT to take forward, but the Governor should ensure that it is actioned and monitored through the Prison Health Partnership Board. .

CONCLUSION

101. The evidence suggests that the man was not an easy person to manage in prison. Although there were periods of calm, he frequently came to the attention of staff for disruptive behaviour. From some of the interviews it seems that he may have become frustrated because he could not communicate effectively.

102. There are several examples of the man attempting or threatening self harm and suicide as a means to obtaining something he wanted. He had also pre-warned staff or called for their attention previously when attempting or threatening to harm himself. On the day he died he had several outbursts regarding his meals and medication, but this was something that had happened before. He did not alert staff that he was going to self harm or attempt suicide – it was his friend who told staff he thought the man would kill himself that night. He seemed cheerful and calm when the assessor went to assess him.

103. The man did not leave any explanation nor are there any obvious triggers why he took his own life. In fact two days before his death he talked to a friend about a re-trial and getting out of prison. Given his self harm history it might have been an impulsive attempt because he thought he would be found in time by the night officer. Alternatively, he may have hidden his intentions from staff.

104. The man had been monitored under the ACCT process on four occasions. The closure of the final ACCT was not in line with correct practice. However, as a consequence of staff concerns for his wellbeing, he was in fact being monitored regularly – indeed, in all likelihood, he was being monitored more frequently than might have been required had the ACCT remained open.

RECOMMENDATIONS

Prison

1. The Governor should ensure that information regarding prisoners on ACCT is communicated effectively at every handover between staff.

NOMS accepted this recommendation at draft consultation stage and said, "Handover procedures will be reviewed to include this information".

2. The Governor should incorporate the findings of this report into the ACCT training package for staff.

NOMS accepted this recommendation at draft consultation stage and said, "The findings of this report will be included in local training".

3. The Governor should ensure that death in custody contingency plans are carried out accurately and that all staff are invited to attend the debrief and provide statements.

NOMS accepted this recommendation at draft consultation stage and said, "Audits on handling a death in custody are now conducted after every death".

4. The Governor should note the issues regarding bullying and remind staff to follow the local procedures.

NOMS accepted this recommendation at draft consultation stage and said, "The Establishments Bullying procedures were re-written and re-published in 2009. Information on the new procedures was published at the time of issue. Training is taking place on the new procedures and is ongoing".

Prison in conjunction with PCT

5. The Head of Healthcare in conjunction with the PCT should ensure that all relevant staff are trained in emergency response management and receive annual refresher training. The Head of Healthcare should audit this annually.

NOMS accepted this recommendation at draft consultation stage and said, "Since September 2009, all nurses who participate in the medical response service are required to attend the "Immediate Life Support Course" run under the auspices of the Resuscitation Council for the UK.

Participants are assessed and are required to demonstrate competency in all aspects of the curriculum before certification is awarded. The course must be refreshed on an annual basis and auditable records of attendance are maintained by the Head of Healthcare".

NOMS

6. I recommend that NOMS considers issuing renewed guidance to provide clarity about when staff should enter a cell during night state.

NOMS accepted this recommendation at draft consultation stage and said, "NOMS will consider whether further central guidance can be developed to assist prisons in developing their local arrangements for unlocking of cells during the night period".

In addition to these formal recommendations, the Governor will wish to note a number of other matters raised in the text.