PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

# A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

**Investigation into the death of a man in November 2013 at HMP Woodhill**

## *Our Vision*

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

This is the investigation report into the death of a man, who was found hanging in his cell at HMP Woodhill in November 2013. He was 21 years old. I offer my condolences to his family and friends.

A review of the man's clinical care at Woodhill was undertaken. The prison cooperated fully with the investigation.

The man had been at Woodhill just three days at the time of his death. During this short time, prison staff interviewed him three times and healthcare staff assessed him twice. No one identified him as at risk of suicide or self-harm and he gave no indication of his intentions. Staff were aware that he had previously self-harmed in custody 2012 and explored this with him but, on the basis of what he said, were reassured that he had no current thoughts of suicide or self-harm.

Assessing the risk a prisoner poses to himself involves balancing the prisoner's demeanour and behaviour against his known risk factors. I am concerned that in assessing the man's risk, information about the more recent incident of self-harm in the community in 2013 was not identified and discussed. This was noted on his escort record, which is designed to communicate such risks when prisoners move between criminal justice agencies. It is clearly important that such information about identified risks is not overlooked. Had it been considered, it is possible that staff would have initiated suicide and self-harm prevention procedures. I am also concerned that there were frailties in the emergency response, including a delay calling an ambulance. While there is no indication that this would have altered the outcome for him, this is a matter I have raised with Woodhill a number of times before and the Governor needs to ensure that all staff involved understand their responsibilities in an emergency.

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

**Nigel Newcomen CBE**
**Prisons and Probation Ombudsman** **June 2014**

**CONTENTS**

## SUMMARY

1. On 5 November 2013, the man was arrested and charged with sexual offences. He was remanded to HMP Woodhill on 7 November. He had served several previous custodial sentences, most recently at HMYOI Glen Parva. He had previously self-harmed in custody.

2. Reception staff noted the man's history of self-harm in custody and that he said he had no current thoughts of self-harm. Although the Person Escort Record (PER) indicated that he had cut his wrists sometime in 2013, there is no evidence that anyone noted this more recent incident of self-harm (apparently in August 2013). Due to the nature of his offences, he was initially identified as a vulnerable prisoner to be kept separate from the general prison population.

3. A nurse discussed his history of self-harm with him at an initial health screen, but the man said he had no such current thoughts and he did not mention that he had cut his wrists within the last three months, or the circumstances which had led to this. The nurse could not recall whether she had seen the PER which referred to this recent self-harm and did not remember whether she had examined his wrists. An officer subsequently interviewed him as part of the prison's first night procedures, when he again said he had no thoughts of suicide or self-harm.

4. The next day, 8 November, a supervising officer (SO) interviewed the man as part of his induction to the prison. The SO noted that he was polite, confident and relaxed. He showed no signs of anxiety and denied having any thoughts of self-harm. He said that he no longer wanted to be considered a vulnerable prisoner and that he would prefer to be allocated to a standard wing and would tell other prisoners that he was in for robbery. That afternoon, he moved from the prison's first night centre to the induction unit. On 9 November, a member of the prison's public protection unit saw him to explain public protection restrictions which would apply to him because of the charges he was facing. Nothing further is recorded that day.

5. On Sunday there were extra checks on all prisoners in the induction unit because of concern about a serious incident of self-harm the day before. Officers checked the man at around 8.00am and again at 8.45am. At 10.12am, an officer delivering mail to prisoners looked through the observation panel on the cell door and saw him hanging by a torn sheet from the light fitting in his cell. The officer immediately went into the cell and cut the ligature. He then radioed an emergency medical response code. He, and another member of staff, tried to resuscitate him. Healthcare staff and paramedics arrived and joined in the resuscitation attempt, but he was pronounced dead at 11.11am.

6. The investigation found that the man had a number of risk factors for suicide and self-harm. The staff at the prison discussed some of these factors with him, mostly relating to his previous time in custody over a year

earlier and, on that basis and from what he told them, they did not regard him as at risk of suicide and self-harm. However, the staff overlooked the fact that this his Person Escort Record reported that he had cut his wrists some time in 2013 and did not question him about the circumstances of this more recent incident of self-harm. We cannot therefore be satisfied that his risk was adequately assessed when he arrived at Woodhill. Had this happened, it is possible that suicide and self-harm prevention procedures would have been initiated. It is not possible to know whether this would have changed the outcome. As in a number of previous investigations into deaths at Woodhill, there were deficiencies in the emergency response which led to a delay in an ambulance being called and in emergency equipment being brought. We make two recommendations about assessing risk and emergency procedures.

## THE INVESTIGATION PROCESS

7. The investigator issued notices to staff and prisoners at Woodhill informing them of the investigation and inviting anyone with information to contact him. No one responded.

8. NHS England, (East Midlands) appointed a clinical reviewer to assess the clinical care that the man received at Woodhill.

9. The investigator obtained all relevant documents from the man's time in prison. He interviewed several members of staff and two prisoners at Woodhill. He informed the Governor of the initial findings of the investigation.

10. We have sent the Coroner a copy of this report.

11. One of our family liaison officers contacted the man's family. They had no specific additional issues they wanted the investigation to cover. The family received a copy of the draft report. They did not make any comments.

## HMP WOODHILL

12. HMP Woodhill has the dual role of a local prison and a high security prison and holds more than 800 men. It takes prisoners from the Magistrates' and Crown Courts in the Milton Keynes area and also holds category A prisoners (prisoners regarded as of high risk to the public should they escape). It has a Close Supervision Centre housing prisoners whose behaviour is especially complex or challenging. There is also a unit for protected witnesses.

13. Central and North West London NHS Foundation Trust delivers health services at Woodhill.

### Her Majesty's Inspectorate of Prisons

14. HM Inspectorate of Prisons' (HMIP) most recent inspection of Woodhill was an unannounced inspection in January 2012. Inspectors noted that the first night centre was well prepared for new prisoners and there were good procedures to ensure that prisoners were safe and provided with key information. The inspectors reported that private interviews to assess prisoners' vulnerabilities were completed on the first night centre and most prisoners reported feeling safe on their first night. Levels of self-harm were high and were noted to have risen since the previous year. Inspectors considered that suicide and self-harm data was insufficiently analysed to lead to improvements. Some deficiencies in ACCT procedures were identified.

### Previous deaths at Woodhill

15. The man's death is the fourth self inflicted death at Woodhill since 2012. There is no similarity between these deaths and that of his, although we repeat a recommendation made in the report of the death of a man at the prison in May 2013 with regard to the emergency response.

### Assessment, Care in Custody and Teamwork (ACCT)

16. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. The purpose of the ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should not be carried out at predictable intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all the actions of the caremap have been completed.

## KEY EVENTS

17. The man had previously served custodial sentences in juvenile and young adult establishments. He had last been released from a sentence at HMYOI Glen Parva on 26 November 2012. On 5 November 2013, he was arrested and charged with sexual offences.

18. On 7 November, the man was remanded into custody at HMP Woodhill. The Person Escort Record (PER) that accompanied him from court to Woodhill, noted that he had a history of self-harm by cutting his wrists in 2013 and that in 2007 he had been diagnosed and treated for Attention Deficit Hyperactivity Disorder in prison (ADHD). (ADHD is a psychiatric disorder in which there are significant problems of attention, hyperactivity, or acting impulsively.) The PER gave no further details about his self-harm in 2013.

19. A Supervising Officer (SO) checked the man into the prison's reception unit at 3.00pm. Officer A, who was in reception at the time, told the investigator that the man agreed with the SO that, because of his charges, he should be held separately from the general prisoner population as a vulnerable prisoner.

20. Officer A completed a cell sharing risk assessment (CSRA) and noted that the man had previously self-harmed, had been violent and abusive to staff in the past and had previously attempted to escape from custody. He was identified as a high risk of violence towards a cell mate and was allocated a single cell. She was not sure that he had fully understood the implications of being a vulnerable prisoner and explained this again. He said he still wanted to be regarded as a vulnerable prisoner. She told the investigator that she believed that he was more worried about other prisoners finding out what he was in prison for, than about coping with prison life.

21. The man told Officer A that he had never shared a cell in custody, before and was not willing to share with anybody. He told the officer that he had previously self-harmed at Glen Parva out of frustration at his situation, but he had no current thoughts of self-harm. She said that he was open and chatty and told her that he had now matured and no longer self-harmed. He said he would let officers know if his mood changed. He did not mention that he had cut his wrists more recently (the post-mortem report indicates that this was three months earlier).

22. At 4.30pm, a nurse completed an initial health screen. The man told the nurse that he had previously been in prison and had a history of self-harm and mental health problems. She noted that although he appeared anxious, this was usual for someone arriving in prison. He said he had no feelings of suicide or self-harm. She noted that he had minor injuries to his knuckles. He told her that he had punched the walls of his police cell out of frustration. Because of his previous diagnosis of ADHD and his history of self-harm, she referred him to the prison's mental health team.

He agreed that this was a good idea. The nurse did not consider that he was a current risk of suicide and self-harm. She told the investigator that she could not recall whether she had seen the PER or whether she had examined his wrists. She does not appear to have noted or been aware of his more recent self-harm in 2013 and therefore did not discuss the circumstances with him.

23. The man was taken from reception to the prison's first night centre where an officer spoke to him and gave him a basic induction to the prison, explaining the rules and regime and how to access facilities and services such as Listeners. (Listeners are prisoners trained by the Samaritans to offer confidential support for prisoners in distress.) The officer assessed his vulnerability and noted that he was polite, open about his situation, made good eye contact and said he had no thoughts of self-harm. He asked if he could telephone his family to let them know where he was. Because of the nature of his charges, the officer did not allow him to make a telephone call to his family but called them on his behalf, telling them where he was and that he was okay.

24. At 6.30pm, a prison GP saw the man, but he declined a full assessment. The GP noted that he looked well, appeared calm and showed no symptoms of substance withdrawal.

25. On the morning of 8 November, SO A interviewed the man as part of the prison's early days' procedures. He told her about his previous time in prison and said that he had been a "nuisance" at Glen Parva and had damaged property and fought with other prisoners. However, he said that he had also got on well with the staff there and had worked as a wing cleaner. She noted that he was, polite, confident and relaxed. She said he showed no signs of anxiety and denied any thoughts of suicide or self-harm. She said he did not appear to be hiding anything and spoke openly and honestly and responded to her questions by looking into her eyes. However, he did not refer to his most recent act of self-harm in 2013.

26. The man told SO A that he no longer wanted to be located in the vulnerable prisoner unit. She said he told her that he had not known that the girl he was seeing was just fourteen or fifteen which had resulted in the charges against him. He said he did not see himself as a sex offender and did not want to go on a wing with older sex offenders. She said she explained to him that there were other prisoners of his age living in the vulnerable prisoner unit and that as a vulnerable prisoner he would still have gym sessions and work opportunities, but separate from the main population. She said that it was apparent that he had already made up his mind. He said he wanted to go the main prison and would tell other prisoners that he was in prison for robbery. She told the investigator that there was no evidence to suggest that he would be at risk from other prisoners if he refused to accept the offer of vulnerable prisoner status.

27. A healthcare assistant completed a second healthcare assessment at around 3.30pm on 8 November. She noted the man's previous self-harm

behaviour and, because of this, she had 'mild' concerns about his risk of further self-harm. She told the investigator that he had denied any thoughts of self-harm and that his presentation and demeanour gave no indication that he was at risk.

28. The man moved from the first night centre, to House Unit 1 Bravo Wing (HU 1B), the prison's induction unit, later that afternoon. As he had been identified as a high risk prisoner he was allocated a cell of his own.

29. On Saturday 9 November, an officer from the prison's public protection unit went to see the man on the induction unit to explain that, because of the nature of the charges he was facing, he would not be allowed contact with anyone under 18. He fully accepted this. The officer told him that because of the charges he could be held separately as a vulnerable prisoner. The officer said that he firmly declined and said that if anyone asked, he would say he was in prison for robbery.

30. As at other prisons, Woodhill operates a restricted regime at weekends and prisoners are locked in their cells for longer periods than during the week. On the Saturday, the regime would have allowed a period or exercise and association and prisoners were unlocked from their cells to collect their meals. All prisoners were looked up at around 5.00pm.

31. The investigator spoke to the two prisoners who had occupied the cell next to the man's. Prisoner A said he had spoken to him on Saturday 9 November, during the association period. He said he had asked him how he was getting on and what he was in for. The prisoner said he told him that he was in for burglary. Prisoner B said he recalled chatting to him a couple of times, but had no meaningful conversations. The prisoner said he appeared to banter with a couple of other prisoners on the wing when unlocked.

32. On Sunday, at around 8.00am, SO B said he briefed staff on the induction unit that, due to an incident of self-harm on the unit the previous day, any prisoner who was not due to be unlocked should be checked to see that they were okay. That day the unit was running a more limited regime than usual because of staff shortages. The man was due to be unlocked at around 11.00am for lunch. Officer B checked him at about 8.15am. He could not actually recall seeing him at the time but was certain he was not hanging.

33. The SO told the investigator that he believed that he had seen it written down somewhere that the man had been harassed the previous day (Saturday) because of the nature of his charges. He said that he had passed this information on to wing staff at the morning briefing so they could watch out for him. He said that because of the information he had planned to speak to the man that morning about him accepting vulnerable prisoner status. Despite this, none of the wing observation books or other documents indicate that he had been harassed and none of the other staff or prisoners we spoke to said that he had encountered any problems

during his time on the induction unit. (When the investigator told the SO that there was no evidence to suggest that the man had been harassed because of his charges, he said it was possible that he had confused this with concerns that he had declined to accept vulnerable prisoner status.)

34. At around 8.45am, the SO also checked on the man. He said that he had checked every cell on the landing that morning and could not recall if he had spoken to him at the time, or whether he was asleep or awake.

35. At 10.12 am, while delivering mail, Officer B looked through the observation panel on the man's cell door and saw him hanging from the light fitting. The officer immediately went into the cell, supported his body and cut the ligature, which was made of bed sheets. He then radioed an emergency code blue which indicates that a prisoner is unconscious, not breathing or has breathing difficulties. The control room then asked the officer to clarify his position. The SO joined him. He checked him for signs of life, but could find none and noted that his body was cold. The officers began cardiopulmonary resuscitation (CPR).

36. A nurse who was in the unit treatment room said he heard the code blue called at 10.12am and went straight to the man's cell, which took about two to three minutes. He did not make a detour to collect the emergency response bag. When the nurse arrived at the cell he asked someone to bring the emergency response bag. He cleared the man's mouth, but could not find a pulse. As he was satisfied that the officers were performing CPR competently, the nurse then went to collect the emergency equipment which had still not arrived. Before he left the cell, the nurse radioed the control room and asked them to call an ambulance. The control room log indicates that an ambulance was called at 10.19am.

37. A healthcare assistant arrived and assisted the nurse with inserting an airway. Another nurse arrived soon after and took over the co-ordination of the resuscitation attempt. She had been at the other side of the prison when the code blue was called and said it took her four minutes to reach the cell.

38. A defibrillator (a life-saving device that gives the heart an electric shock in some cases of cardiac arrest) was attached to the man but found no trace of electrical activity in the heart and advised that no shock should be given. The staff continued CPR until paramedics arrived shortly after 10.30am. He was pronounced dead at 11.11am.

**Family Liaison**

39. A prison chaplain acted as the prison's family liaison officer. The chaplain and a prison manager went to the man's mother's home that afternoon and informed her of his death. In line with Prison Service guidance, the prison contributed towards funeral expenses.

## Hot debrief

40. A hot debrief was held for the staff involved in the emergency response to give them the opportunity to share their feelings and for support to be offered. Those involved said they found it helpful and that they had been well supported by the prison's care and welfare team.

## Post-mortem report

41. A post-mortem examination concluded that the man's death was caused by hanging.

## ISSUES

### Assessing risk or suicide and self-harm

42. Prison Service Instruction (PSI) 64/2011, management of prisoners at risk of harm to self, to others and from others (Safer Custody), and PSI 74/2011 (Early Days In Custody), both list a number of risk factors and potential triggers for self-harm and suicide. These include early days in custody, impulsiveness, previous self-harm, young age, being charged with a violent offence and a history of mental health problems. PSI 74/2011 requires new prisoners to be interviewed in reception to assess the risk of self-harm and expects all staff to be alert to the increased risk of suicide and self-harm posed by prisoners in those categories and act appropriately to address any concerns, including opening an ACCT if necessary. Once a prisoner is placed on an ACCT plan they are assessed to see what support is needed, supervised more closely and reviewed frequently until the risk is reduced.

43. Staff judgement is fundamental to the ACCT system. The system relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. It is not an exact science. PSI 64/2011 requires all staff who have contact with prisoners to be aware of the triggers and risk factors that might increase the risk of suicide and self-harm and take appropriate action. We have considered whether staff at Woodhill should have identified the man as at risk of suicide and self-harm and opened an ACCT.

44. Although the man did not suffer from any mental illness, he had previously been diagnosed with ADHD which can lead to impulsive behaviour and reckless behaviour. He had also told staff that he had a history of self-harm and said that his self-harm had been triggered by frustration at his situation. Just a day or two before he arrived at Woodhill, he had punched his cell wall at the police station, which could be regarded as an act of self-harm. This had led to minor injuries to his knuckles which a nurse at Woodhill had noticed. He was newly arrived, in an adult prison for the first time and, although apparently at ease, at least one member of staff thought he appeared anxious. The decision about whether to go to the vulnerable prisoner unit or not must also has been unsettling. Although the SO believed that the man had been harassed because of the nature of the charges against him, this does not appear to have been the case. If it had happened, we would have expected staff to have re-assessed his risk of suicide and self-harm urgently at that stage.

45. In the short time the man was at Woodhill, three members of prison staff interviewed him and concluded that he was not at risk of suicide and self-harm. Two members of healthcare staff also reached the same conclusion. Although the reception nurse had referred him to the mental health team, this was a routine referral and not because of any immediate concern.

46. However, we are concerned that none of the staff who assessed the man's risk of suicide and self-harm appeared to have identified from the PER that he had self-harmed by cutting his wrists some time in 2013. No further enquiries were made and all the discussions about his self-harm centred on his previous time in custody at Glen Parva in 2012. Despite an otherwise relatively thorough assessment, the reception nurse, who had noted his injured knuckles from his time in police custody, was unable to recall whether she had seen the PER or examined his wrists. We understand that the 2013 self-harm incident was three months previously, yet none of the staff who assessed him in reception or on his first night spoke to him about this to find out the circumstances.

47. Most of the staff indicated that they had relied on the man's personal presentation and his assurances that he did not intend to harm himself. A prisoner's presentation is obviously important and reveals something of their level of risk. However, it is only a reflection of their state of mind at the time they are seen by the member of staff and should be considered as a single piece of evidence used to make a judgement of risk. All risk factors must be collated and considered to ensure that a prisoner's level of risk is holistically judged. He had a number of risk factors, some of which the staff appeared to take into account, although this was not always clearly recorded.

48. In the absence of the additional information on the PER about his recent self-harm, we might have agreed that it was reasonable to decide that an ACCT did not need to be opened. However, the failure to consider and discuss with the man his more recent incident of self-harm means we cannot conclude that there was a fully considered assessment of his risk which took into account all important information. It is vital that information about risk communicated in PERs is not overlooked. It is possible that had this information been fully considered and discussed by the staff involved they might have concluded that the weight of the risk factors outweighed their perceptions of his mood and demeanour and led to an ACCT being opened. We cannot know whether managing him under ACCT procedures would have affected the outcome, but it should have led to additional support being provided. We make the following recommendation:

    **The Governor should ensure that reception and first night staff consider and record all available risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, particularly those identified in suicide and self-harm warning forms and PERs.**

**The emergency response**

49. Officer B acted swiftly when he discovered the man hanging. He immediately cut the ligature, called an emergency medical code blue and began to attempt resuscitation. This should have resulted in the control

room calling an ambulance automatically and staff bringing the appropriate emergency equipment to the cell.

50. An ambulance was not called until 10.19, seven minutes after the code blue, when the nurse radioed to ask for one to be called. The nurse had also had to leave the cell to get the emergency response bag and defibrillator as no one had brought it to the cell. The emergency equipment was in an unlocked room, accessible to all staff on the unit and in a good emergency response it should have been collected and taken to the cell ready for the emergency response nurses when they arrived.

51. Prison Service Instruction (PSI) 03/2013 Medical Emergency Response Codes, which was issued at the beginning of February 2013, required governors to have a medical emergency response code protocol based on the instruction by the end of February 2013. This should instruct staff how to communicate the nature of a medical emergency using agreed emergency codes and ensure that the control room calls an ambulance automatically as soon as an emergency code is called.

52. At the time of the man's death, Woodhill had introduced a protocol for calling an emergency code but it did not clearly set out that the control room should call an ambulance immediately a code blue was received. The local protocol instructed that staff should collect emergency equipment ready for healthcare staff when they arrived, but this was not done. We cannot say that these delays affected the outcome for him but in such emergencies a swift response is vital.

53. Since the man's death Woodhill has amended its protocol in respect of calling ambulances, which we welcome. However, we have investigated a number of deaths at Woodhill where we have been critical of emergency procedures. We consider that further guidance and training is needed to ensure that all staff understand their responsibilities and roles, including taking emergency equipment to the scene of an incident, and that the new procedures are thoroughly embedded. We make the following recommendation:

**The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Woodhill's Medical Emergency Response code protocol complies with PSI 03/2013 and:**

- **Provides guidance to staff on efficiently communicating the nature of a medical emergency;**
- **Ensures staff called to the scene attend as quickly as possible and bring the relevant equipment; and**
- **Ensures there are no delays in calling, directing or discharging ambulances**

## RECOMMENDATIONS

1. The Governor should ensure that reception and first night staff consider and record all available risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, particularly those identified in suicide and self-harm warning forms and PERs.

2. The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Woodhill's Medical Emergency Response code protocol complies with PSI 03/2013 and:

    - Provides guidance to staff on efficiently communicating the nature of a medical emergency;
    - Ensures staff called to the scene attend as quickly as possible and bring the relevant equipment; and
    - Ensures there are no delays in calling, directing or discharging ambulances

ACTION PLAN: The Man - **HMP Woodhill November 2013**

| No | Recommendation | Accepted/Not accepted | Response | Target date for completion | Progress (to be updated after 6 months) |
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| **1** | The Governor should ensure that reception and first night staff consider and record all available risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, particularly those identified in suicide and self-harm warning forms and PERs. | Accepted | All prisoners are screened when they enter the establishment. Information is sourced from the PER, 2050 if available, C-Nomis and any other information received from the Police via the escort contractor.<br><br>Any prisoner who has had their licence revoked will have their C-Nomis history live and available when they are admitted into reception. This will now form part of our initial screening. The process includes a series of interviews in both Reception and the First Night Centre with both discipline and healthcare staff. At each stage, prisoners are asked if they feel suicidal or have any thoughts of self-harm. Decisions on whether to place a man onto an ACCT are determined by the responses of the individual and any previous known history which will form part of the overall decision making. Staff | 31 Dec 13<br>Functional Head<br>Governor<br>SIN 359/13 published on 29-11-13 highlighting risks of self-harm and triggers of which staff working in these areas should be aware when dealing with new prisoners into custody. Staff also informed of QuickTime learning documents highlighting national learning. | |

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| | | | will use the ACCT process as appropriate.<br><br>Safer custody team are to conduct a review of processes and provide guidance and instruction to all staff involved with the first night and induction process taking into consideration significant risk factors.<br><br>The Safer Custody functional Head has provided instruction to staff working within the Induction unit and reception areas personally. This included highlighting to staff recent learning from both local and national sources with increased importance of noting any comments reference self-harm issues contained within the PER document and other relevant risk factors e.g. licence recalls, first time in custody etc. A Supervising Officer working in the area has also met with the staff individually to ensure they have a full understanding of the process and issued to them a copy of SIN 359/13. | Completed. April 30th 2014<br><br>Completed 18-03-2014 by Governor /SO. | |
| **2** | The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 | Accepted | PSI 03/2013 Medical emergency response codes was published on 01-02-2013 with an effective date of the 28-02-2013 by NOMS. | Safer custody | |

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| | and their responsibilities during medical emergencies and that Woodhill's Medical Emergency Response code protocol complies with PSI 03/2013 and:<br><br>a) Provides guidance to staff on efficiently communicating the nature of a medical emergency; | | HMP Woodhill published a staff information notice 044/ 2013 in response to this highlighting this policy to all staff on the 20-02-2013. Staff were also provided with a detailed flow chart of actions for them to take when dealing with a medical emergency this formed part of staff information notice 044/13.<br><br>A further SIN 360/13 was issued on 29-11-2013 giving step by step guidance on actions to take when dealing with emergency incidents.<br><br>A further SIN 003/14 was published on the 09-01-2014 which clearly instructs control room to call a blue light ambulance immediately upon hearing a code red or code blue emergency.<br><br>Staff responding to either a code red or a code blue will collect the emergency response bag which is fully equipped to deal with incidents en route to the scene these are located in the green cabinets on the 2nd level by the core offices. House unit 5 emergency equipment is located in both the treatment room and by exit onto | Safer Custody<br><br>Completed by safer custody. SIN 360/13 reissued 29-11-13<br><br>Current practise SIN 003/14 Final draft published. | |

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| | b) Ensures staff called to the scene attend as quickly as possible and bring the relevant equipment; and<br><br>c) Ensures there are no delays in calling, directing or discharging ambulances | | exercise yard. This instruction has been relayed to all medical staff by Healthcare management.<br><br>Contingency plans are available and are immediately implemented as part of this requirement which will ensure emergency vehicles are directed to the scene without delay.<br><br>A review of the current risk assessment and protocols is to take place to improve discharge of prisoner in an emergency. However preservation of life will always take priority over security. | 31 Jan 2014<br>Completed by SO<br><br>Governor to provide final update to recommendations made by safer custody. | |