

**Investigation into the circumstances surrounding the  
death of a man, a prisoner  
at HMP & YOI Holme House in July 2010**

**Report by the Prisons and Probation Ombudsman  
for England and Wales**

**January 2012**

This is the report of an investigation into the death of a man, a prisoner at HMP Holme House, who was found hanging in his cell in July 2010. He was 42 years old. I extend my sincere condolences to his family and to his many friends who have been affected by his death.

The investigation was conducted by my investigator. A clinical review of the medical care given to the man was commissioned by the local Primary Care Trust. I am grateful to the clinical reviewer for her review.

I would also like to express my thanks to the Governor and staff at Holme House for their assistance during the course of this investigation. In particular, I thank the Governor and the liaison officer for their liaison with my investigator throughout the investigation.

The man was not a stranger to Holme House. He was a well-liked and trusted prisoner who had not previously expressed any desire to harm himself when he was in prison. On this occasion, he expected to be bailed into the community but was remanded into custody instead. Staff said that he did not give any indication that he would harm himself and were very shocked when, after four days back in prison, he apparently took his life. He was found by an officer and staff attempted cardio pulmonary resuscitation (CPR). Unfortunately, it was unsuccessful and he was pronounced dead at 2.06pm.

My investigation has concluded that there was some uncertainty amongst staff about the procedures for completing Prisoner Escort Records (PER). These weaknesses do not appear to have impacted adversely in the man's case, but they are critical issues which require improvement. Accordingly, I make four recommendations, one relating to mental health assessments and another regarding alcohol withdrawal procedure and staff training. The other two recommendations relate to administrative processes in the completion of Prisoner Escort Records and follow up procedures when risks are apparent.

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**

**January 2011**

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## SUMMARY

The man had previously been in HMP Holme House in 2009 and again in April 2010 for a short time. On these occasions he told healthcare staff that he had been sectioned under the Mental Health Act seven years previously and diagnosed with psychosis. He also asked staff for help with withdrawing from alcohol misuse and was prescribed appropriately.

On 26 July, the man was remanded into Holme House again. He attended a healthscreen and told staff that he drank up to ten pints of normal strength lager every day but he did not think that he was dependent on alcohol. On this occasion, he did not tell staff about his previous mental health problems and said that he had no thoughts of harming himself. Staff said that he did not seem to be suffering from alcohol withdrawal symptoms, nor did he seem depressed.

The man was allocated a double cell to himself on the induction wing of the prison. Staff who worked on this wing knew him well and he was a trusted prisoner who knew the prison regime and appeared to settle in well.

On 28 July, the man appeared at Crown Court to try to secure bail into the community. Staff completed a Prisoner Escort Record (PER), which gives information about any risks that a prisoner might pose, and gave it to the escorting staff. The man showed "suicidal possibilities". Staff told my investigator that this information was taken from two computer systems and referred to information given when he had harmed himself in 1999. It had not been updated since then and staff were unsure about what historical information should be put on the PER form. The escort staff who took him to court spoke to him about his feelings regarding harming himself and were satisfied that he was not at risk. He was not granted bail and subsequently returned to Holme House. There is no record of any follow up to the PER form on his return to prison or of any further discussion with him that day.

On 29 July, staff saw the man in the morning and again at lunch time. He appeared to be no different to usual. He collected his lunch and ate half of it. At 1.50pm a Physical Education Instructor went to his cell to take him for a gym induction. He saw that he was hanging by his neck from a ligature made with bedsheets. The officer immediately called for assistance and both discipline and healthcare staff attempted to resuscitate him. Unfortunately, they were unsuccessful and he was pronounced dead at 2.06pm.

Prison managers, including the prison family liaison officer contacted the man's family later that afternoon to break the news and offer their assistance. Funeral expenses were subsequently paid in full. A debrief was held and staff were offered support.

The investigation has identified the need for improvements in relation to mental health referrals. However I have been informed that referral procedures by Tees Esk Wear Valley Mental Health Trust were put in place in September 2010, after the man's death. Prior to this there were no operational guidelines for referrals to be made. I have therefore withdrawn the previous recommendation in relation to these procedures. I identified shortcomings in alcohol withdrawal management during the

reception process and I make a recommendation on this aspect, as well as those mentioned above regarding completion and follow up of information on PER forms.

## THE INVESTIGATION PROCESS

1. The investigation was opened on 4 August 2010 when my investigator issued notices announcing the investigation to staff and prisoners. The notices included an invitation to those who wished to submit information related to the man's death to make themselves known to the investigator. No prisoners came forward. She met the Governor and members of the Independent Monitoring Board (IMB) and Prison Officers' Association and discussed deaths in custody at Holme House. She also spoke to one of the officers who found him on 29 July. She spent time looking around houseblock 4, where he lived from 26 July to 29 July and spoke to staff.
2. The investigator was given access to the man's prison files, including his medical records. She later returned on 16 September and 19 October to interview staff and make further enquiries.
3. A clinical review of the man's healthcare, whilst he was in custody was carried out by a clinical reviewer on behalf of the local PCT.
4. One of my family liaison officers contacted the man's family to advise them of the investigation and invite them to raise any matters they would like to be addressed. Although his mother had a number of concerns, she said that she did not want any further information about the investigation.
5. The man's mother asked about whether he had a cell bell, where it was, whether it had been in good working order and whether he had pressed it at any time. She also asked if the prison was aware of her son's mental health problems and previous self-harm. I have endeavoured to address her concerns in this report. She will be sent a copy of the report and invited to make comments and ask any further questions.
6. The family have received a copy of the report and decided that they did not want to make any comments. They will receive a copy of this final report.

## **HMP & YOI HOLME HOUSE**

7. Holme House is a category B prison for unconvicted, convicted and sentenced male adults. It opened in May 1992. On arrival into prison, prisoners are risk assessed and given a category based on their offence and the risk that they pose to the public should they escape. There are four categories: A, B, C and D. Category B are prisoners for whom the highest security conditions are not necessary but for whom escape must be made very difficult. The prison primarily serves the communities of the Tees Valley, South West Durham, East Durham and North Yorkshire. It has six residential units, known as houseblocks one to six. It has an operational capacity of 994.
8. NHS Durham is the provider of healthcare services at Holme House. There is an in-patient unit with 28 beds and 24-hour nursing care. An out-of-hours doctor service is covered by the prison doctor with help from an emergency out-of-hours doctor service.

### **Previous deaths in HMP Holme House**

9. Since 2004 when my office became responsible for investigating deaths in custody, there have been 37 deaths prior to the man's and three more deaths since his. Previous reports have included recommendations about obtaining a prisoner's medical history, particularly where there are psychiatric problems. This office has previously recommended that all entries to medical records should show the reason for the action and, in April 2010, the National Offender Management Service accepted a recommendation that the Head of Offender Health should review record keeping.

### **HM Inspectorate of Prisons**

10. HM Inspectorate of Prisons conducted an unannounced follow-up inspection of Holme House in March 2009. However, a further inspection was carried out in July around the time of the man's death but the results were not available when this report was written. The 2009 inspection found that suicide and self-harm prevention work was of a high quality, though there was little evidence or understanding of triggers for self-harm. Mental health provision was described as reasonable, although there were no day care services. The Inspectorate recommended that the review of mental health services should ensure that the deployment of mental health nurses is sufficient to cover primary mental health needs.

### **Independent Monitoring Board (IMB)**

11. Each prison in England and Wales has an Independent Monitoring Board, which is made up of volunteers from the local community. The Board is responsible for monitoring day-to-day life in the prison and to ensure that proper standards of care and decency are maintained. The 2009 annual report published by the IMB for HMP Holme House does not raise any issues which are relevant to this investigation.

## KEY EVENTS

12. The man was remanded into custody to Holme House, for an alleged domestic related incident on 26 July. He had previously been in custody at Holme House on two occasions, once from 24 August to 18 December 2009 and again from 3 April to 13 April 2010. He was well known to staff at the prison and was regarded as a trusted and well liked prisoner. Although he had previously suffered with depression and, in 1999 had harmed himself, he gave no indication that he was feeling suicidal on this occasion.
13. On reception at the prison all prisoners have a healthscreen conducted by nursing staff. It is noted in the man's clinical record that, when he was there in August 2009, he told healthcare staff that he was drinking approximately ten pints of lager a day and felt dependent on alcohol and would like some help to withdraw. At that time, staff noted "Evidence of early withdrawal symptoms" and he was subsequently prescribed chlordiazepoxide, which is medication to reduce the symptoms of withdrawal.
14. When the man was again in custody in April 2010, he completed an alcohol screen and again reported drinking ten pints of lager a day but this time said that he did not need any clinical help to detoxify. His healthscreen in April was completed by a nurse. He told the nurse that he had been sectioned under the Mental Health Act in 2000, due to psychosis. He also said he was not currently receiving treatment for mental health problems and "was fine at present". The clinical reviewer asked the nurse if he considered making a mental health referral when he told him about his previous mental health problems. The nurse replied that he had not completed a referral because he presented as well at this time but he would have referred him if he displayed any behaviour which caused concern.

## 26 and 27 July

15. When the man was again remanded into custody on 26 July, he was examined by a nurse. He told her that he did not have any thoughts of suicide or self-harm and she recorded that he made good eye contact, meaning that she did not think that he was being evasive. He told her that he drank about 40 pints lager a week but denied that he was dependent on alcohol. In interview, she said that she was aware of how someone would appear if they were withdrawing from alcohol but he did not show any of these signs. She noted at the bottom of the healthscreen that there were "no drugs or alcohol abuse". There was no comment on the healthscreen about his mental health, or any information about previous self-harm or psychiatric treatment in the community.
16. At interview, the nurse said that she had asked the man about his mental health and, because she had not written anything on the record, she deduced that he had not told her he had previously suffered from mental ill health. She told my investigator, that if he had told her he had been involved with mental health services in the past she would explore what had happened, how long ago that

was and how he presented currently and would make a decision based on that information, whether to refer him on to mental health inreach team.

17. The man then moved to houseblock 4, an induction wing for prisoners coming into the prison. They normally stay there for four or five days to attend induction classes to learn about the prison regime and can apply to have a gym induction. His cell was on landing 3 and he was in a double cell on his own. There were no prisoners in the cells on his side of the wing but the cells opposite were occupied.

## **28 July**

18. Two days after his remand to Holme House, on 28 July, the man went to Crown Court in order to try to secure bail into the community. Bail was not granted and he was remanded back to Holme House. When a prisoner moves around the criminal justice system, either to another prison or to court, a Prisoner Escort Record (PER) is completed by staff. It begins in an administrative office in the prison or court and information is obtained from computer records about any risks that the prisoner may pose to themselves or others. Two boxes have to be completed. One at the top asks for details of current and relevant risks and another at the bottom of the form is for health risks. The form is then passed to healthcare staff who can add any health related issues that might be apparent. The escorting officer keeps a chronological log of events relating to the prisoner during each journey. If the prisoner returns to prison, the PER should be handed to the custody staff. When any healthcare, self-harm or suicide concerns are raised, the prisoner and the form should be seen by healthcare staff and appropriate action taken.
19. Medical records indicate that the man did not attend for a nurse appointment on the morning of the bail hearing, although this is not clear why as he went to court at 1.50pm. A number of potential risk areas are highlighted on the PER, one of them being "suicidal possibilities". The form was signed by the Custody Manager, although it was clear that the risk section of the form had been completed by someone else because the writing is different. The bottom part of the form relating to health was ticked as "no known risks".
20. At interview, the Custody Manager told my investigator that the PER form was required over the office lunch period and there was only one other member of staff in the office who could operate the two computer systems to obtain the risk information. She asked the other member of staff to complete the risk section with information from the computer and she then signed the form at the bottom. She said that the information about the man's suicidal possibilities came from information on the Police National Computer and prison system 5, (A prison computer database.) and was dated 1999.
21. Whilst the man was at court, one of the escorting officers discussed these risks with him. He subsequently noted the following in the ongoing record at 2.33pm.

"Prisoner interviewed and SSH (suicide and self harm) warning form not commenced. He spoken to in regards to SSH (suicide and self harm)

markers on PER. He states that he has no thoughts of SSH at this time. Situation to be monitored whilst in our care.”

22. When he returned to Holme House, the man was taken back to the same cell on houseblock 4. There were still no other prisoners next door to him. There is no record of him having been assessed by healthcare staff on his return to the prison and no other record of any contact with him that day and no further follow up to the PER is recorded.

## **29 July**

23. The next day, 29 July, the man had his breakfast around 8.00am as usual. Officer A said that he had a short conversation with him although he could not remember what they talked about. He told my investigator that the man was “... just the same as he always had been. Certainly threw no alarm bells as to being different in any way.” When my investigator asked what he would have been doing on the morning of 29 July, staff were unable to tell her. As he was on the induction wing, he would normally be in a class. However, staff had allowed him to sign that he had completed the induction because he had been at Holme House previously and so knew everything that they were going to tell him.

24. My investigator spoke to one of the induction officers and was told that it was most likely that the man would have gone for exercise from 9.00am to 10.00am if he had not attended induction. After that, he would have been locked in his cell until lunchtime. My investigator has been unable to confirm this or to find out if he had any interaction with other prisoners or staff that morning.

25. At approximately midday, Officer B unlocked the man’s cell to allow him to get his lunch. He said that he would have probably been out of his cell for around 15 to 20 minutes whilst he was at the servery. He then returned to his cell with his meal and the officer locked him back into his cell over the lunch period. The officer told my investigator that when he returned to his cell he “... seemed ok ... He didn’t give us any cause for concern. Went into his cell and he sat on his bed, pulled his table up in front of him and I went and closed the door”. The officer asked him if he was in the cell by himself and he replied “Yes boss”. He said that it looked as though he was ready to eat his meal. (It was subsequently discovered that he had eaten half his lunch.)

26. At 1.50pm, a PEI went to the man’s cell to take him for a gym induction. He told my investigator that he opened the hatch to the cell door before going into the cell and saw him “with his back to the wall underneath the cell bars ...” (The external windows of the cell have bars attached.) The PEI thought that this was strange and noticed that his eyes were open and some of his cell furniture had been moved. He then opened the cell door and realised that the man was hanging by a ligature made of bedsheets. The ligature was tied round his neck and attached to the cell bars. His bottom was slightly raised off the floor.

27. The PEI immediately shouted “staff” for help. Officer A, who was on the other side of the landing ran to the cell because he knew something was wrong by the way the PEI had shouted. He said the distance from where he was standing to

the man's cell was about 30 feet and it took him just seconds to get there. Other staff, including Officer B, who were very close to the cell also responded to his call and someone pressed the general alarm bell. Staff told my investigator that when the emergency alarm bell is pressed, it sounds throughout the prison and anyone nearby should attend as well as healthcare staff.

28. The PEI used his cut down tool to cut the ligature from the window bars and Officer A supported the man's weight. The officers then laid him on the floor in order to perform cardio pulmonary resuscitation (CPR). They checked but there was no pulse. They then cut the ligature from around his neck and also noticed some blood on the floor and near to his hand. Neither took much notice of the blood because it seemed superficial and they prioritised beginning CPR.
29. Officer A started giving chest compressions at a ratio of 30 compressions, to two breaths. He told my investigator that he had been trained in first aid approximately four years before, during his training as a prison officer. The PEI told my investigator that he was a qualified first aider and, as a Physical Education Officer, his first aid training and qualification was up to date at all times.
30. Officer A said that healthcare staff arrived at the cell "roughly two to three minutes" after the officers started CPR. Nurse A told my investigator that she was very close to houseblock 4 when she heard the general alarm bell sounding. Although she was not the emergency response nurse, she knew that she was closer to houseblock 4 than Nurse B, who was on the rota as emergency nurse. She said that as the emergency call was a general alarm, nursing staff would not ordinarily be expected to take any emergency bags with them. Staff explained that general alarms would normally be activated when there had been a fight or some violence and healthcare staff would be expected to attend in case of any injury.
31. Nurse A said that she ran up the stairs to houseblock 4 and on to the landing, where she heard staff calling for a nurse. She said it took her about 30 seconds to get there from hearing the call. She was the first nurse to arrive at the cell. As she ran towards the cell, other staff handed her gloves and, as soon as she went inside, she called for a defibrillator. (A defibrillator is an electrical device which is used to try and get the heart back into a rhythm after a heart attack.) She took over chest compressions and then attached the defibrillator. As she was doing this, Nurse B arrived and the two officers were asked to leave, so that there was more space to work. Nurse A continued with compressions and Nurse B attached the ambu bag. (An ambu bag is a hand held device used to provide positive pressure to ventilate a patient who is not breathing.)
32. Nurse A said that the man was "cyanosed, (Cyanosed refers to the blue colour that a person's skin colour changes to when there is a lack of oxygen), he was unresponsive, he had a very deep marked ligature mark around his neck". In respect of the defibrillator, she said that it determined that there was no shockable rhythm or electric activity and to continue CPR. The nurses continued CPR until the doctor arrived. As per the National Institution of Clinical Excellence guidelines, the doctor pronounced him dead at 2.06pm after ten minutes or more

of CPR had been administered without a response, with no electrical activity on the defibrillator and as his pupils were fixed and dilated.

33. The staff who discovered the man and responded to the emergency were invited to a hot debrief. (A hot debrief is a meeting held as soon as possible after a major incident to discuss what happened and to provide support for those involved.) There were no prisoners on the wing who were considered at risk of harming themselves. I understand that staff, including Officer B, who responded to the assistance call and attended the cell in the first few moments, escorted the wing prisoners into the yard for exercise. All the staff were offered support by the care and welfare team and some were able to go home after the police had finished taking statements and the hot debrief had taken place. Some found the meeting helpful and others did not.
34. The man's family were told of his death by a Senior Officer (SO) who is a trained prison family liaison officer and a manager, at 4.20pm that afternoon. The prison paid the full funeral expenses and offered the man's mother the opportunity to visit the cell where her son had lived during the short time spent in prison.
35. Prison staff told my investigator that they knew the man as he had been at Holme House on a number of occasions. He was a well liked prisoner and was generally given the job of cleaner, which is a trusted position. Staff said that on this occasion, they did not think that he was any different to when he had been in prison previously. They said that they had no reason to think that he would take his own life. Officer A, who had met him every time he had been in Holme House said, he was "exactly the same, absolutely no difference whatsoever in his general demeanour".

## ISSUES

### Clinical care and assessments

36. The man had been in custody at Holme House on three occasions within a year. He had a documented history of alcohol misuse and mental health conditions, including at least one episode of harming himself. Each time he told staff of his alcohol use but only on one occasion prior to his most recent sentence did he say that he felt dependent on alcohol. On that occasion he was provided with medication to assist with any withdrawal symptoms.
37. Although the man had previously told staff that he had suffered from mental health problems, he did not indicate that this was the case on 26 July and he did not appear to staff to have an existing mental illness. The clinical reviewer notes that "Healthcare staff were over-reliant on the self reporting from him around his alcohol and mental health issues". However, she concludes that it was "unlikely that his death could have been prevented even if emergency procedures, mental health risk assessment and care planning had been robust". At the time of his death there were no operational guidelines stating that if previous mental health issues were raised at the healthscreen a referral should be made to the mental health inreach team. However, I understand that since his death Tees Esk valley Mental Health Trust put such guidelines in place in September 2010 and this is fully utilised by staff.
38. The clinical reviewer makes a recommendation relating to alcohol withdrawal assessments which I endorse and slightly recast.

**The Head of Healthcare should arrange for staff to update their assessment skills in regard to alcohol withdrawal management and ensure that this is implemented appropriately.**

### Person Escort Risk assessment

39. When the man went from Holme House to Crown Court on 28 July his PER was needed urgently. Staff originally thought that the bail request would be made over a videolink but the Judge had asked for him to attend court. The PER was therefore completed over the lunch hour when only one member of staff was in the office. She took the information from the computers and wrote on the PER that he had "suicidal possibilities". The information about suicidal possibilities was drawn from a marker on the computer that he had harmed himself in 1999 and, although historical, the administrative staff decided that it should be included on the PER form. Staff said that they had not been told what to write if issues were historical or how far back to search in the records. The form was passed to the custody manager who signed it and gave it to the healthcare assistant who checked the records and signed that he had no health issues that would raise his risk.
40. Staff at court spoke to the man to check that he was not currently likely to harm himself or commit suicide and were satisfied that he was not at risk of doing so at that time. When he returned to Holme House there were no entries recorded or

follow up to the PER form by either custody or healthcare staff. It is likely that this was because he did not seem to have any issues or tell staff of any suicidal thoughts.

41. Whilst prison staff did not make any follow up enquiries as to the man's wellbeing when he returned to prison, checks were made at court and staff said there was nothing in his demeanour to indicate that he would have taken his life. Staff who saw him during the morning and early afternoon of 29 July reiterated that he gave no indication of feeling depressed or likely to harm himself. Even if he had been reviewed when he returned from court, there is nothing to indicate that he would have told staff that he was considering harming himself, thus potentially changing the outcome. He had some opportunity to talk to staff about any concerns he may have had on the morning of 29 July when he went to get his meals. However, if he had attended induction or some structured activity, with others, on that morning it may have been possible to observe any change or difference in his mood or demeanour. The Governor should therefore remind staff that induction attendance is important for all prisoners, regardless of whether or not they have been in custody at Holme House previously. The clinical reviewer makes recommendations about healthcare contributing to the PER assessments, as well as staff training in completion of the PER forms and follow up enquiries when a prisoner returns to prison. I make the following recommendations on these issues.

**The Governor and Head of Healthcare should ensure that all staff are fully trained and aware of the relevant information to be included on the Person Escort Record. This information should be dated and it should be noted when and where the risks were raised.**

**The Governor and Head of Healthcare should ensure that staff thoroughly check all Person Escort Records when a prisoner comes into the prison. If risks are identified, the prisoner should be assessed by healthcare and discipline staff and a note made as to any other follow up which is required.**

#### **Emergency response on 29 July**

42. When the PEI found the man hanging in his cell he did not use an emergency call code but called for "staff". My investigator was told that emergency calls are normally only made over the radio and the PEI was not carrying one at the time. The clinical reviewer comments that there was a slight delay in the clinical response because the call for assistance was not an emergency call.
43. Nevertheless, it is clear to me that although a code blue emergency call was not made, both clinical and discipline staff responded with urgency and efficiency. There was clearly good team working and a combined response. I agree with the clinical reviewer that it is unlikely that the man's death could have been prevented had a different call been made when he was found. However, the Governor should remind staff of the importance of using the emergency codes when appropriate, in order that the correct response is activated.

## **Family concerns**

44. The man's mother asked if he had a cell bell and whether he had used it on 29 July. My investigator made enquiries and visited the cell. The cell had a fully working cell bell on the right hand side of the door. When a cell bell is pressed a light comes on outside the cell door and a buzzer sounds in the corridor and in the central office. It was working properly when my investigator visited the cell where he died. Staff said that cell bells were tested daily and that he had not pressed it during his time at Holme House.

## **CONCLUSION**

45. The man had been a prisoner at Holme House twice before. He was well known to staff and, on his most recent remand into custody, his demeanour and conversations gave no indication that he was likely to take his life.
46. Documentation from the man's previous times in custody at Holme House indicated that he had been diagnosed with mental illness and had also misused alcohol. The PER form prepared for his court visit the day before his death made mention of the possibility of self-harm. Although this information does not appear to have been acted on when he returned, staff who had contact with him on the day that he died said that he was no different than usual. He did not complete the full induction which meant that he was alone in his cell for lengthy periods, only coming out on 29 July to collect his meal.
47. I conclude that staff could not have reasonably foreseen the man's actions. However, it is important that better assessments and support are provided to prisoners when mental health or alcohol misuse issues are identified, either in the reception process or subsequently.

## RECOMMENDATIONS

1. The Head of Healthcare should arrange for staff to update their assessment skills in regard to alcohol withdrawal management and ensure that this is implemented appropriately.

The prison has accepted this recommendation and said "Training is ongoing to staff and System 1 incorporates new assessment tools and templates". The target date for all staff to be trained is January 2011 and this training will be included in the induction process for new staff.

2. The Governor and Head of Healthcare should ensure that all staff are fully trained and aware of the relevant information to be included on the Prisoner Escort Record. This information should be dated and it should be noted when and where the risks were raised.

The prison has accepted this recommendation and said this is now in place. "All Prisoner Escort Forms (PERs are completed by staff who are trained in their completion including healthcare staff. The security staff also record information in relation to suicide or self harm risk giving both markers and dates. All escorts to court, police productions and transfers are accompanied by PER forms."

3. The Governor and Head of Healthcare should ensure that staff thoroughly check all Prisoner Escort Records when a prisoner comes into the prison. If risks are identified, the prisoner should be assessed by healthcare and discipline staff and a note made as to any other further follow up required.

The prison has accepted this recommendation and said this is now in place and always was in place. They responded that "On arrival in reception the PER form is thoroughly checked by a member of Reception staff. The prisoner is also seen by a member of Healthcare staff working in reception and they also check the PER forms."