

**Investigation into the death of a man
in January 2012 at HMP Elmley**

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

December 2012

This is the report of an investigation into the death of a man. The man was found hanging in his cell. I offer my condolences to his family and friends.

The investigation was carried out by one of my investigators. A clinical reviewer was commissioned to undertake a review of the man's clinical care while in custody. Staff at HMP Elmley co-operated fully with the investigation

The man was in prison for the first time. He was only six days into his sentence and was still on the induction wing. During the late morning on the day of the man's death, he was told that he would be moving to a different wing that afternoon and that he should pack his possessions over the lunch period. When staff unlocked prisoners after lunch, they found the man hanging in his cell. He could not be resuscitated.

On his arrival, the prison did not judge the man to be at risk of suicide or self harm. However, not all available information about his risk was considered, as some important information about his state of mind when he was arrested was not passed on by the police and other information was not flagged by probation staff for immediate attention. It is possible that, had all the information been taken into account, he might have been made subject to closer monitoring. I am also concerned that the emergency response after the man was found hanging was too slow and there was a delay in calling an ambulance. While these concerns are unlikely to have affected the outcome for the man, the Governor of Elmley needs to ensure staff understand the importance of a swift response in an emergency – something we highlighted in another recent investigation into a death at the prison. I am pleased to see that the National Offender Management Service have accepted the recommendations.

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.

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Prisons and Probation Ombudsman

December 2012

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SUMMARY

1. The man was convicted and on 11 January 2012 was sentenced to five and a half years imprisonment. He arrived at HMP Elmley that day. He had not been in prison before. His pre-sentence report, available on the Offender Assessment System (OASys), noted that he had suffered from depression as a teenager, and he reported similar feelings to the writer of the report. The self-harm warning section of his Person Escort Record (PER) noted that when arrested the man was lying in his bath after drinking three bottles of vodka. It did not include the fact that there was also a noose hanging from his loft.
2. On arrival at Elmley, prisoners are taken into the reception centre in Houseblock 1. The man participated fully in the reception procedures, which included a health screening. His PER was available to staff, but the pre-sentence report (on OASys) was not. Staff who saw him did not note any signs of distress. He was then allocated a cell on A Spur (a spur is an individual wing within a houseblock), which is the first night accommodation.
3. On 12 January, the man had a secondary health screening which raised no issues. Over the coming days, neither staff nor prisoners noticed any problems with the man. Although he did not socialise much, he spoke easily and openly with staff.
4. Because of the nature of his offences, the man was due to be moved to the vulnerable prisoners' unit, on B Spur of Houseblock 1. However the unit was full, so he remained on the induction spur until a space became available. During the morning of the man's death, he was told that a space had become available, and that he would be moving to B Spur that afternoon. Although he queried whether he needed to move, he appeared not to be worried about this.
5. After collecting their meals, prisoners were locked in their cells shortly after midday. The member of staff who locked the man's door spoke to him, and did not notice anything untoward. However, when doors were unlocked at approximately 2.00pm, the man was found suspended from the toilet door by a torn bed sheet. The prison officers who initially found him did not cut him down immediately. This was done some minutes later by an officer who subsequently arrived on the scene. There was also a delay in calling an ambulance. Prison and healthcare staff attempted to resuscitate him, but this was unsuccessful and, at 2.26pm, the prison doctor pronounced that the man had died.
6. We make four recommendations about information for risk assessments, information sharing between agencies, and the emergency response arrangements.

THE INVESTIGATION PROCESS

7. This office was informed of the man's death on the day of his death 2012. The investigator issued notices to staff and prisoners informing them of the investigation and inviting anyone with relevant information to contact the investigator. No further information was received.
8. The investigator visited HMP Elmley on 20 January 2012. The prison provided him with the man's prison and medical records. He also met the deputy governor and was shown around the prison, including the man's cell. The investigator spoke to prisoners who knew the man, a member of the Independent Monitoring Board, and the Chair of the Prison Officers' Association. On subsequent visits he also met with the Governor.
9. A clinical reviewer was commissioned to carry out a clinical review of the man's care and treatment while in custody. The investigator and clinical reviewer conducted joint interviews of healthcare staff.
10. The investigator interviewed 14 members of staff. He provided verbal and written feedback to Governor at Elmley during the investigation.
11. The investigator wrote to HM Coroner to inform her of the investigation and to obtain a copy of the post mortem report. This investigation report will be sent to the Coroner to assist her enquiries.
12. One of the Ombudsman's family liaison officers contacted the man's nominated next of kin, who was a friend. She outlined the purpose of the investigation and invited him to ask any questions or raise any concerns. He raised no issues at that time, nor in response to the draft report.

HMP ELMLEY

13. HMP Elmley is part of the Sheppey cluster of prisons, which also contains HMPs Standford Hill and Swaleside. Elmley serves courts in Kent and holds both remanded and sentenced adult men, as well as unsentenced male young offenders (those aged 18-21 years). It holds up to 1,252 prisoners in five houseblocks, with a mixture of single, double and triple cells.
14. Eastern and Coastal PCT commission healthcare services at Elmley. The healthcare centre includes a 29-bed inpatient unit, treating patients with both physical and mental health issues.

Previous deaths at Elmley

15. Since the Ombudsman's office took over responsibility for investigating deaths in prison custody in 2004, there have been six self-inflicted deaths at Elmley including the man. There has been one death since. We have previously made a recommendation about the process for calling ambulances, and it is regrettable that we have to make a similar recommendation in this report.

Her Majesty's Inspectorate of Prisons (HMIP)

16. The last report published on Elmley by HMIP was of an unannounced follow-up inspection in April 2009. The report found that:

“Elmley is a busy local prison and its transient population presents a wide array of risks and needs. There had been some progress since our last inspection and the prison was slightly less crowded, except for one house block. Aspects of work to ensure safety had improved, although we remained very concerned by the arrangements to manage prisoners at risk of suicide or self-harm.”

17. The report goes on to say that all new arrivals were taken to the first night and induction centre in Spur 1 of houseblock 1 where there was a good overall focus on prisoner safety.
18. In response to a previous recommendation, HMIP reported that the prison had relocated vulnerable prisoners to two spurs on the induction unit on houseblock 1. This meant that first night and induction officers based on the houseblock could ensure that all prisoners had access to the same induction arrangements.

Independent Monitoring Board (IMB) report

19. The IMB is made up of unpaid volunteers from the local community responsible for monitoring day-to-day life in the prison to help ensure that proper standards of care and decency are maintained. The last annual

report published by the IMB for Elmley covered the year ending 31 October 2011 and concluded:

“It is the view of the Board that in the year under review the prison has maintained a good standard in most areas of care.”

20. The investigator spoke to a member of Elmley’s IMB. The member said that the Board did not have any major concerns about the prison. Specifically, they had not seen any evidence of problems in the induction process. He confirmed that the man had not made any applications to the IMB during his short time at Elmley.

KEY EVENTS

21. The man had not been in prison before. He was both hard of hearing, and dyslexic. In the short time he was in Elmley, he did not receive any visits or make any telephone calls.
22. A pre-sentence report completed on the man was contained within his Offender Assessment System (OASys) records. The report shows that he had received some treatment for depression when he was 18. He said that this related to circumstances at the time, which included the ending of a relationship, and a lack of friends or family support. He said that he underwent a brief period of counselling, but had never contemplated harming himself. The report notes that the man said he was once again feeling the same emotions that he had at that time.
23. On 11 January 2012 at Canterbury Crown Court, the man was sentenced to five years and six months in prison for a number of sexual offences. He was taken to HMP Elmley the same day.
24. When prisoners are moved between different areas of custody, including from court to prison, they are accompanied by a Person Escort Record (PER). This should contain any important information about them, including any particular risks they may present. Under the heading of risk of suicide or self-harm, the man's PER notes that when arrested he was found in the bath having consumed three bottles of vodka. The PER also notes under health risks that he suffered from problems with his back.
25. The man arrived at Elmley at 6.17pm. The prison is divided into houseblocks, and within each houseblock are individual spurs. The man went to A Spur on Houseblock 1, which contains the first night centre. He was taken through the induction process by Officer A. The induction process involves a number of different people covering different areas of prison life. The officer began the process with an interview with the man lasting approximately ten minutes. The officer said in interview that he was aware of the information on the PER form about when the man was arrested, and he asked the man whether he had any thoughts of harming himself. He said that the man stated he had no thoughts of harming himself and the officer had no reason to believe he was not telling the truth. The officer said he did not have the pre-sentence report with the information relating to the man's previous depression.
26. Part of the induction process involves an interview with an Insider, a prisoner who has been trained to welcome new prisoners, help with any concerns, and explain the processes they will encounter in their first days in the prison. The insider saw the man and told the investigator that the man said that it was his first time in prison and he had no particular issues he wanted to discuss.
27. Nurse A carried out a routine initial health screen of the man to assess immediate mental or physical health needs. The man told the nurse that

although he felt slightly stressed, he had been expecting a longer sentence than that which he actually received, and was happy with the outcome. The nurse noted on the medical record that the man engaged fully in the reception process, made good eye contact and maintained a good body posture, appearing at ease and answering all questions. He denied any thoughts of wishing to harm himself, and the nurse found no indicators that the man might want to do so. He said that he had no problems with substance misuse and, apart from having blocked ears, said he suffered from no physical health problems. The nurse did not have the man's pre-sentence report. The nurse is a Registered Mental Health Nurse (RMN) and he noted that the man's mental state appeared stable and that the man did not display any depressive or psychotic symptoms. He advised the man how to get support if he found difficulty in coping in prison, and made a referral to the doctor to assess his hearing.

28. Officer A noted on the man's file that he participated with all parts of the induction process. After his induction, the man was taken to a cell on A Spur. The following morning, Insiders on the wing noticed that he appeared "quite chirpy". There were no indications of any problems.
29. On 12 January, the man saw Healthcare Assistant (HCA) A for a follow-up, secondary health screening (which is a more in depth assessment of a prisoner's mental and physical health). The HCA had access to the man's medical file, but not his OASys report.
30. After seeing HCA A, the man saw Dr A, one of the prison's doctors, to have his hearing assessed. The doctor concluded that there was a build-up of wax. He gave the man ear drops to take, and made an appointment to have his ears syringed on 18 January.
31. Because of his offences, the man was due to be housed on the vulnerable prisoner unit, on B Spur, of Houseblock 1. However, the unit was full, so he remained on the first night centre pending a vacancy. He had a single cell at the end of the corridor on the third floor landing.
32. The investigator spoke to three of the Insiders, who also lived on the third floor landing of the first night centre. They all remembered the man during his time on the wing and on the landing. They noted that he did not come out of his cell much and remained quite isolated, but that he did not seem troubled or to have any specific problems.
33. An adviser for the Tribal Group (an organisation which assesses prisoners' literacy and helps prepare them for employment after their release) saw the man on 12 January. They agreed that the man would undertake a literacy course, and they discussed potential next steps after he completed that. The adviser said that the man was open, friendly and engaged during their conversation. At no point did he give any indication that he might harm himself.

34. Because of the nature of his offences, the man was required to sign the Sex Offenders' Register. On 16 January, Elmley's public protection Officer, Officer B, visited the man in his cell. The officer explained that he would need to sign the register and adhere to a Sex Offender Prevention Order upon release. The man said that he understood the process, and he signed the necessary notifications. He asked some questions about his sentence, and Officer B told him that he would shortly receive full information which would explain the process further. The officer said that the man gave no indication of being distressed. The conversation lasted approximately 10 minutes, after which the officer said the man thanked him for explaining the process.
35. One of the Insiders told the investigator that he saw the man on the morning of 17 January. He said he did not notice anything untoward in the man's demeanour, and he seemed to be okay. As he was still living on the induction spur, he did not have any work to attend and remained in his cell that morning until 11.00am, when prisoners had a period of association. At approximately 11.30am, Officer C told the man that a space had become available for him on B Spur and that he would be moving there that afternoon. He told him to pack his possessions during the lunch period. The officer said that the man asked whether he had to move, and the officer informed him that he did. The officer told the investigator that the man appeared to accept the situation.
36. The routine for lunch is that prisoners collect their meals and return to their cells to eat. They are then locked into their cells at approximately 12.15pm. Officer D locked the cells on the third landing that lunchtime. When he locked the man's cell, at approximately 12.15pm, he saw that the man was sitting on his bed.
37. Unless prisoners have any medical needs, or are on any special monitoring measures, they are not checked during the lunch period. Officers patrolling the wings at this time will usually only open the cell observation panels if prisoners press their cell call bells. None of these applied to the man so he was undisturbed in his cell until the doors began to be unlocked at approximately 1.50pm. Officer E was unlocking the cells on the third landing and, when he reached the man's cell at approximately 2.00pm, he was unable to see him fully through the cell door observation panel. He therefore opened the door and found the man hanging from the toilet door by a ripped bed sheet. The officer called for assistance and stepped outside the cell.
38. A number of officers responded. Officer F was the first to arrive, he estimated about ten seconds after Officer E's shout for help. He saw that Officer E was outside the cell and went in and saw the man hanging. Officer F said in interview that the sight "took him aback" and he stepped back out of the cell. Officer E had radioed the prison's control room with a Code Blue emergency (meaning a prisoner is not breathing) and asked for medical assistance. The Control Room log notes that the Code Blue call was made at 2.01pm.

39. At this point, Officer G arrived. He saw Officers E and F outside the cell, the door of which was now closed and locked. Not knowing what the emergency was, Officer G unlocked the cell and went in. He then saw that the man hanging. Senior Officer (SO) H arrived immediately behind Officer G and also went into the cell. Officer G said to him "he's gone". SO A saw that the man was hanging and was not moving. He lifted the man to allow Officer G to use his anti-ligature knife to cut the man down, and they laid him on the cell floor. Officer G checked his wrist and neck for a pulse but could not find one. He noted that the man's skin was discoloured.
40. Temporary SO B arrived as Officer G and SO A entered the cell. He also went in, saw that the man was hanging, and immediately went to the office to use the telephone to inform the communications centre. The communications centre log shows that this call was made at 2.07pm. He then informed Governor A, who was the duty governor.
41. Officer H had responded to the call for assistance and started a log of events. She noted that Officer G cut the man down at 2.04pm. Officer I also responded to the call, saw that staff were dealing with the situation in the cell, so stepped back outside and began to keep a record of who came onto and who left the landing. Officers H and I each kept notes timed by their own watches, so there are minor discrepancies with the timings.
42. Nurse B was designated as the first responder to any healthcare emergencies that day. When Officer E called the Code Blue over the radio, she was in the prison's healthcare centre with Healthcare Assistant (HCA) B. They took the medical emergency response bag and immediately made their way to Houseblock 1. HCA B estimated that they arrived there two minutes after receiving the call. They were met by two officers who directed them to the man's cell. The logs note that they arrived at either 2.09pm or 2.10pm. An officer said to Nurse B that the prisoner "had gone". They arrived at the cell just as Officer G was checking the man for a pulse, and were told that he had been found hanging.
43. Nurse B applied a defibrillator (a machine that detects whether there is any heart activity that might respond to electrical stimulation), which did not detect any activity. She and HCA B could not find any sign of life, and noted that the man's skin was blue. Nurse B put an airway tube into his throat, and delivered oxygen to him while chest compressions were carried out.
44. It was confirmed that an ambulance had been called, and a doctor was requested from healthcare. The Control Room log notes that a doctor was asked to attend the houseblock at 2.09pm, and an ambulance was called, at Governor A's request, at 2.13pm.

45. Prison doctor Dr B arrived at the man's cell at 2.23pm. She found the man on the floor, with staff attempting to resuscitate him. They told her that they had been doing so for 20 minutes. The doctor assessed the man and checked his airway and the defibrillator, which indicated that there was no response to the resuscitation attempt and no shock was required. She could detect no signs of life and pronounced the man dead at 2.26pm. Very shortly afterwards, the ambulance paramedics arrived at the cell. The paramedics confirmed the doctor's assessment that the man had died.

Informing the man's next of kin

46. The man had nominated a friend of his as next of kin. Reverend A was appointed as the prison's family liaison officer and, at 5.25pm, he and Governor B left the prison to go to the friend's address where they informed him of the man's death. The prison later received some information that the man had an uncle, so the following day the Reverend and the governor visited him and informed him of his nephew's death.

Debrief

47. After a death, prison managers should hold a "hot debrief". This is a meeting of all the staff who were involved in finding and attempting to resuscitate the prisoner. The meeting should focus on reassurance, information sharing and how staff can support each other. A debrief was held that afternoon. This included prison officers and healthcare staff, although Dr B was not able to attend. Staff were offered appropriate support.

Informing staff and prisoners

48. Notices informing staff and prisoners about the man's death were issued that afternoon. All prisoners who were subject to special monitoring measures for those thought to be at risk of harming themselves had their circumstances reviewed. Support was offered to prisoners on the houseblock. The man's death was discussed at a prisoner representatives meeting, who were told how support could be accessed. Listeners (prisoners trained by the Samaritans to support other prisoners) were briefed.

Post Mortem

49. A post mortem was carried out on 23 January 2012. The doctor concluded that the man's death was due to "suspension".

Funeral

50. The man's funeral was held on 7 February. It was conducted by the prison Chaplain, and the prison met the costs.

Further information

51. Following the man's death, Kent Police conducted an investigation, as is routine with all deaths in custody. The investigation discovered that when the man was arrested, police found the hatch to the loft in his house was open, and a noose was hanging through it. This information was not passed to the prison.
52. After the man died, a friend who was sorting his possessions found two sealed letters, held in a strongbox. These letters were addressed to two friends and were messages based on the assumption that they would be read after the man had died. The letters indicated that he intended to take his own life and had been written some time before he was arrested and taken to Elmley.

ISSUES

Reception health screening and the man's healthcare

53. The man was in prison for just six days before he took his own life. Apart from his initial health assessments and treatment for the problem with his hearing, he had no contact with healthcare.
54. The reception health screening and secondary screening were both carried out in a timely manner. There were no particular issues raised in either screening. The man was hard of hearing. This was noted at his reception health screening, and he was given a doctor's appointment the following day. At that appointment, he was given ear drops and a further appointment made to have his ears syringed. We are satisfied that the problem with the man's hearing was identified and addressed appropriately.

Assessment of risk

55. The man's pre-sentence report for the court referred to a time when he had previously received treatment for depression. While this was many years previously, he told the report writer that he had the same emotional feelings that he had felt at that time. Neither prison officers nor healthcare staff who took part in the man's reception process and initial suicide and self-harm assessments knew about this information, and it had not been identified to the prison as a matter of concern by probation staff responsible for the report.
56. It is not possible to say whether the man would have been treated differently had this information been available when he arrived at Elmley. Nurse A is a mental health nurse, as well as being experienced in dealing with people arriving in prison. As such, he could be expected to identify any signs of distress or depression, and he records that he did not see any in the man. Neither did anyone else who interacted with the man during his time in prison. The man had told the nurse who examined him in police custody that he had taken an overdose when he was 18, but this information was not shared with the prison. The clinical reviewer writes that all relevant details concerning previous medical history should be provided to clinical staff in a timely manner. It does not appear that information from pre-sentence reports on OASys, which might contain important information, was available to reception and first night staff responsible for making assessments on prisoners arriving from court or police custody. The information about his previous suicide attempt was not included on the PER, information from his pre-sentence report would have been in the prison.
57. When police arrested the man, he was in the bath and had apparently consumed three bottles of vodka. There was also a noose hanging through the loft hatch in his home. Only part of this important information was passed to the prison on the PER. The information about the noose

was not shared by the police with either the escort staff or prison staff. Therefore it was not taken into account when the man's risk was assessed on arrival at Elmley. This was important information that could have influenced the assessment of the man's risk when he arrived at the prison. Similarly, probation trust staff could have flagged up the information in the pre-sentence report. Effective information sharing between agencies is critical and we therefore make the following recommendation:

The Governor should discuss the man's case with senior leaders of local criminal justice agency partners to improve understanding of the need for important information about risk of suicide and self-harm to be shared effectively, and should develop mechanisms to enable prison staff carrying out assessments of newly arrived prisoners to have quick access to all relevant information

58. Letters, written by the man, were discovered after his death. These indicated he was thinking of taking his own life and had apparently been written some time before he was arrested and imprisoned. The prison could not have been expected to be aware of this, but the combination of information from the police and the pre-sentence report might well have raised concerns about the man's risk of suicide and self-harm, particularly as a newly arrived prisoner who had never been in prison before.

The emergency response

59. When Officer E found the man suspended from the cell toilet door by torn bedsheets, he left the cell and called for assistance. He also radioed through to the communications centre. Other staff arrived at the man's cell within what all involved said was a very short space of time. Officer F arrived first went in the cell and saw the man hanging. He was shaken by what he saw and stepped back out of the cell. When Officer G reached the cell, the door was locked. Neither Officer E nor Officer F remembered closing the door.
60. National guidance to prison staff who find a prisoner hanging states that the immediate response should be to cut the prisoner down, release the ligature, check for signs of life and then, if necessary, begin resuscitation. Neither Officer E nor Officer F did this. It was therefore some minutes before the man was cut down. Officer H noted that Officer G cut down the man at 2.04pm, but SO B said he arrived as Officer G was entering the cell, saw the man hanging and rang the communications centre immediately. That call was made at 2.07pm. The logs note that the nurses arrived at either 2.09pm or 2.10pm, when Officer G was checking the man for a pulse. This would suggest he had just been cut down. At that stage CPR had not been started. It therefore appears that the man could have been left hanging for up to five or six minutes after he was found. Once he was cut down healthcare staff immediately began efforts to resuscitate him. The clinical reviewer confirms that it is unlikely that commencing resuscitation earlier would have made a difference in this

case. Nevertheless, there should always be an immediate response when a prisoner is found hanging, and in some cases it could save a life. We make the following recommendation:

The Governor should ensure that all staff are reminded of, and understand, the importance of an immediate and appropriate response when a prisoner is found hanging.

61. The communications centre log shows that at 2.07pm SO B had informed them of a death. At this point it had not been confirmed that the man was dead. In interview, SO B said that, although he saw the man hanging and was fairly sure that he was dead, he believed that he informed the communications centre and the duty governor of a possible death. An ambulance was not called until Governor A requested one at 2.13pm. An emergency ambulance should have been called by the officers as soon as the man was found hanging. By the time Governor A called one there had already been a delay of at least twelve minutes. It is difficult to understand why this took so long.
62. Guidance to staff in the communications centre for summoning an emergency ambulance refers to an ambulance being requested by "Oscar 1 or healthcare"¹. While there is no policy at Elmley that says that ambulances should only be called by the orderly officer or a member of healthcare staff, the wording of the guidance suggests that this is the case. We understand that the guidance has been amended since the man's death and staff have been reminded that ambulances should be requested by any member of staff if necessary. We draw the Governor's attention to the letter from the Chief Executive of the National Offender Management Service and Director of Offender Health (February 2011) which requires all ambulance protocols to be reviewed to ensure timely and immediate access to both the prison and individual prisoner:

The Governor should ensure that all members of staff understand that they should call an emergency ambulance immediately when a prisoner is found hanging or appears seriously ill.

63. A request for a doctor to attend the man's cell was made at 2.09pm, yet Dr B did not arrive until 2.23pm. She was unable to be certain why it took so long for her to arrive, although she did state that she had turned her radio down as she was in outpatients and felt that the radio was obtrusive. As a result of this delay healthcare staff continued resuscitation attempts for around 20 minutes before the doctor's arrival, their understanding being that only a doctor could make the decision to stop resuscitation. The doctor said when interviewed that it was clear that the man had been dead for some time. The clinical reviewer is concerned that there does not appear to be any clear policy in relation to healthcare roles and responsibilities in the event of an emergency response and we share this concern:

¹ Oscar 1 is the orderly officer, the manager responsible for the daily running of the prison.

The Governor should ensure that there are well understood, and practised, contingency arrangements to deal with emergency situations, which set out clear roles and responsibilities for prison and healthcare staff.

CONCLUSION

64. The man was in prison for just six days before being found hanging. He underwent both reception and secondary health screening and was appropriately treated for a hearing problem.
65. The man did not show any signs of distress or give any reason for staff to consider that he might harm himself. However, we are concerned that key information which should have been considered as part of his reception interview was not available to prison staff. While such information might have prompted further monitoring and assessment of the man, it is not possible to say whether this would have altered the outcome.
66. When the man was found hanging, the two officers who initially attended were shocked and did not follow appropriate procedures. They left the cell and did not attempt to cut the man down or resuscitate him. Other staff were on the scene shortly afterwards and did so. The clinical reviewer considers that it is unlikely that commencing resuscitation attempts any earlier would have made a difference in this case, but it is vital that action is taken immediately a prisoner is found hanging as in some cases it can save lives.
67. There was a delay in the doctor attending the man's cell, which resulted in healthcare staff continuing with resuscitation attempts for around 20 minutes. There was also a delay in calling an ambulance. The roles and responsibilities of all staff involved in an emergency response need to be clear and practiced so that in a future emergency there is no misunderstanding.
68. Despite the concern about some information about risk being missing this report considers that overall prison staff could not have been expected to have anticipated the man's actions. All who saw him, including prisoners, formed the impression that he was coping reasonably well and he gave no indication of intent to take his own life.

RECOMMENDATIONS

1. The Governor should discuss the man's case with senior leaders of local criminal justice agency partners to improve understanding of the need for important information about risk of suicide and self-harm to be shared effectively, and should develop mechanisms to enable prison staff carrying out assessments of newly arrived prisoners to have quick access to all relevant information.

This recommendation was accepted. The National Offender Management Service (NOMS) commented:

"The Governor will use future meetings held with Criminal Justice partners to re-enforce timely, clear and comprehensive sharing of information with regard to issues of risk."

2. The Governor should ensure that all staff are reminded of, and understand, the importance of an immediate and appropriate response when a prisoner is found hanging.

This recommendation was accepted. A notice has been issued to staff supporting the national guidance.

3. The Governor should ensure that all members of staff understand that they should call an emergency ambulance immediately when a prisoner is found hanging or appears seriously ill.

This recommendation was accepted with the comment:

"Amended guidance to staff in relation to the summoning of an ambulance [through the Control Room] will also be subject to a Notice to Staff and this will be further cascaded through line briefings."

4. The Governor should ensure that there are well understood, and practised, contingency arrangements to deal with emergency situations, which set out clear roles and responsibilities for prison and healthcare staff.

This recommendation was accepted. NOMS commented that:

"HMP Elmley is subject to six contingency exercises per year. The Death in Custody contingency plan has been reviewed and tested. Further changes have been made."