A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man on 27 December 2013 at HMP Dovegate

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 prisoner, who died from head injuries sustained after jumping off his bed at HMP Dovegate, on 27 December 2013. He was 52 years old. I offer my condolences to his family and friends.

The investigation was carried out by one of my investigators.

The man had been released from prison on licence in January 2013. He was recalled on 14 December, after incidents of drug misuse and paranoia which his probation officer considered increased his risk of reoffending and risk to the public. He was in a hospital psychiatric unit when his licence was revoked, probation staff liaised with the hospital due to their concerns regarding his increased risk to the public and his ability to leave the hospital at will. They were told that should he attempt to leave the hospital arrangements were in place for him to be sectioned under the Mental Health Act. The prison was not told about the circumstances of the man's recall until two days after he arrived and at that stage initiated suicide and self-harm prevention monitoring. The man seriously harmed himself on 22 December and, after hospital treatment, was moved to the prison's healthcare unit. He was constantly supervised as he was regarded as a very high risk of suicide and self-harm. On 27 December, while he was being supervised by an officer from outside his cell, he leapt head first onto the floor from his bed and suffered serious injuries. Resuscitation attempts were unsuccessful and a prison GP confirmed that he had died.

While I understand that probation staff had grounds to consider that the man's risk of reoffending had increased, I am satisfied that the probation service has provided evidence that they had consulted with staff at St Georges Hospital. However, the assurances provided by the hospital in relation to actions that would be taken should he try to leave the hospital were not adequately communicated to those responsible for his care in hospital on the weekend of his recall. Had this happened, it appears likely that he would have been detained under the Mental Health Act and not returned to prison.

When he first arrived at Dovegate, insufficient consideration was given to his risk of self-harm but, when additional information became available two days later, mental health staff acted swiftly to implement suicide and self-harm prevention measures. Although there was room to improve some aspects of these measures, I am satisfied that a multidisciplinary team worked well together to provide a high level of suicide prevention and mental health care and that, overall, the man received good support at Dovegate. I am, however, concerned that the inexperienced officer required to provide constant supervision of him was not adequately trained or briefed, nor properly supported after his death.

It was most unfortunate that because of his recall, the man did not continue to receive the hospital treatment he evidently needed, but I do not consider that anyone at the prison could have realistically predicted or prevented his tragic and shocking actions on 27 December.

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

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SUMMARY

1. The man had been released on licence from prison in January 2013, after serving eight years in custody. On Saturday 14 December, his licence was revoked as a result of reports of drug misuse and concerns about his paranoiac behaviour which reflected the circumstances of his original offence. Police arrested him while he was in a hospital psychiatric unit recovering from a suicide attempt by drug overdose. His probation officer had discussed the recall to prison with the hospital and had been assured that should he attempt to leave the hospital he would be sectioned under the Mental Health Act. He was taken to HMP Dovegate, but police and probation staff did not initially inform the prison of the full circumstances of his recall.

2. A reception health screen recorded that he had some physical health problems, including asthma, but no mental health problems were identified. However, he told the nurse that he had recently self-harmed and a risk assessment indicated that he was at high risk. In spite of this assessment and his other risk factors, such as his recall to prison, suicide and self-harm prevention measures were not begun. The medication the man needed was not prescribed until two days later.

3. On Monday 16 December, his probation officer telephoned to inform the prison’s mental health team about his background. She explained that he had recently taken a significant overdose of prescribed medication which had resulted in him being in a coma for three days. After he had recovered, he had been admitted as a voluntary patient to a hospital psychiatric unit for a period of mental health assessment, which was ongoing at the time of his recall. In light of this information, two mental health nurses from the prison’s primary care and mental health in-reach teams assessed him and started Prison Service suicide and self-harm prevention procedures, known as ACCT. They then sought further information about his past mental health history.

4. The man continued to be monitored under ACCT procedures and supported by the mental health team. However, on 22 December, he seriously cut his hand with the lid from a food tin and was taken to hospital. When he returned, he was admitted to the prison’s healthcare unit. He was regarded as a high risk of suicide and self-harm and his level of observation was raised to constant supervision. This meant that a member of staff would monitor and support him continuously, mostly from outside his cell door.

5. On the morning of 27 December, a mental health assessment concluded that he remained a high risk of suicide and self-harm. He then returned to his cell to wait for a case review scheduled for 10.30am.

6. An officer, who was a relatively new member of staff with no previous contact with prisoners, had been assigned to supervise him that day. She said that after his assessment, he appeared agitated and paced about his cell. At around 10.30am, while she and the man were having a conversation, he stepped onto his bed, which was about 12 inches from the floor, with his hands in his trouser pockets.

The officer told him to get down, but he leapt from the bed and landed head first on the ground. She had no keys and therefore could not go into the cell, so she called to nearby staff for assistance.

7. Staff went into the cell within seconds of the officer raising the alarm. The man was unconscious and bleeding heavily and they immediately began attempts to resuscitate him. An ambulance was called, but before paramedics arrived, the prison GP had attended and, at 10.50am, pronounced him dead.

8. We are concerned that, although the man had been admitted to hospital for assessment and treatment, he was recalled to prison despite discussion with those responsible for his psychiatric care by the probation officer. In spite of his recent history of self-harm, additional risk factors and a high score in a risk assessment conducted at reception, little consideration was given to implementing the suicide and self-harm prevention provisions when he first arrived. However, once additional information came to light two days later, prison staff began to monitor him immediately and he received very good care and support from a multidisciplinary team. Although his overall care was good, the investigation identified some weaknesses in updating care plans and it seems that staff resource issues, rather than the man's needs, influenced some of the earlier decisions about his the level of monitoring.

9. Finally, we are concerned that his supervision immediately before his death was carried out by a member of staff who had had no training in the monitoring procedures, had not been fully briefed about the role and had been given no keys to access the cell in the event of an emergency. Despite the traumatic event of witnessing his death on her first day of direct contact with prisoners, she received no support afterwards.

THE INVESTIGATION PROCESS

10. On 2 January 2014, the investigator, issued notices to staff and prisoners at HMP Dovegate, informing them of the investigation and inviting anyone with relevant information to contact him. No one responded.

11. The investigator went to Dovegate on 7 January and obtained copies of the man's prison and healthcare records. He visited the healthcare unit and saw the cell he had occupied.

12. NHS England, Shropshire and Staffordshire, commissioned a review into the man's clinical care.

13. The investigator interviewed six members of staff at Dovegate on 27 February. After the interviews, he gave the Director written feedback about the initial findings of the investigation.

14. We informed the local coroner of the investigation and we have sent a copy of the investigation report to him.

15. One of our family liaison officers, and the investigator visited the man's wife on 12 February to explain the purpose of the investigation and give her the opportunity to raise any matters she wished the investigation to address. She had the following questions and concerns:

    - Why was her husband initially allocated to a standard residential wing and not monitored as a risk of suicide and self-harm when he had transferred from a mental health hospital after a serious suicide attempt?
    - Why was he not transferred back to hospital when his probation officer informed the prison of his circumstances?
    - How was he able to harm himself with a tin can on 22 December, when he was subject to suicide and self-harm monitoring?
    - Why did the prison not inform her of her husband's admission to hospital on 22 December or return her calls?
    - The suitability and training of the officer supervising her husband on 27 December and whether she had access to keys.
    - The suitability of the cell for constant supervision and its operation.
    - Was his medication appropriate and was it ever refused?
    - Was the emergency response appropriate?
    - His wife was content with most aspects of the prison's family liaison, but was concerned that the family liaison officer evaded some questions such as about the supervising officer and the availability of CCTV recordings. She was concerned that her husband's recall papers had been removed from his cell before his property was returned to his family.

16. The investigator visited the man's son at HMP Featherstone to discuss the investigation with him.

17. Following the issue of the draft report Staffordshire and West Midlands Probation provided evidence indicating that they had consulted with staff at St Georges in relation to the man and the increased risk that felt he posed. They were told by staff at St Georges that should he attempt to leave the hospital arrangements were in place for him to be sectioned under the Mental Health Act. Unfortunately, these arrangements were not communicated to those staff responsible for his care on the weekend of 14 December and as a result the police were able to return him to custody.

18. The investigator and the Family Liaison Officer, met with the man's wife on 25 June to discuss the content of the draft report and her feedback to the findings. This has led to some amendments to factual inaccuracies identified in the draft report highlighted by his wife.

HMP DOVEGATE

19. HMP Dovegate, which is near Uttoxeter, is privately run by Serco. It holds over 1,100 adult men, both on remand and sentenced. Healthcare services are provided by NHS England, Shropshire and Staffordshire.

Her Majesty's Inspectorate of Prisons

20. HM Inspectorate of Prison's (HMIP) last inspection of Dovegate was in October 2011. Inspectors noted that self-harm monitoring was of a good standard, with multidisciplinary and meaningful reviews for those at risk of self-harm. HMIP found good relationships between the prison and healthcare staff, and that relationships between staff and prisoners had improved since the previous inspection.

Independent Monitoring Board

21. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community to help ensure that prisoners are treated fairly and decently. In their annual report for the year ending September 2013, the IMB commented that the safer custody meetings were well attended by prison managers, which they felt contributed to making Dovegate safer. They found that when the numbers of prisoners on suicide and self-harm prevention monitoring increased, there was a reduction in self-harm and they regarded the prison as relatively safe. The IMB was concerned that there was a shortage of nurses with only four registered mental nurses in post at the time.

Previous deaths

22. Since January 2013, there have been four self-inflicted deaths at Dovegate, including this one. The investigation found no similarities between earlier investigations and this case.

Assessment, care in custody and teamwork (ACCT) procedures

23. 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. If a prisoner is considered to be at very high risk of suicide, staff can implement constant supervision, which means the prisoner must be watched at all times. 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

24. In January 2013, the man had had been released on conditional licence, from HMP Grendon after he had served eight years of a twelve-year sentence for attempted murder. The man had been treated for drug and alcohol misuse, asthma, hypertension, dental and back pain, but had no history of psychiatric problems or major mental illness.

25. On 7 December 2013, he took a significant overdose of amitriptyline, an antidepressant, which had been prescribed by his GP. He was taken to Queen's Hospital, Burton-on-Trent, where he remained in a coma for two days. When he recovered, he was admitted to the psychiatric unit of St George's Hospital in Stafford as a voluntary patient, for assessment. During the period leading to his admission to hospital, he had reportedly misused illicit drugs and had become paranoid, both factors in his previous offence. The Probation Service considered this increased his risk of reoffending. His probation officer revoked his licence and recalled him to prison as she was concerned he could leave hospital at any time. She did discuss this with the hospital which had planned to detain him under the provisions of the Mental Health Act 1983, if he attempted to leave the ward. However, these arrangements appear to have not been sufficiently communicated to those staff at the hospital responsible for the man on 14 December and the police arrested him in hospital and returned to custody at HMP Dovegate on Saturday 14 December.

26. Reception staff noted that the police had brought the men to Dovegate as a result of his recall to prison, but they had no information about the circumstances and the police had not completed a Person Escort Record, which accompanies prisoners on all journeys and is used to communicate risk factors. The only documents available to them were the documents authorising his return to custody, which stated that his recall was due to 'poor behaviour'.

27. A nurse completed an initial health screen. He noted that the men appeared calm and settled, had a history of asthma and had been prescribed a number of medications for physical health problems, including an inhaler. He recorded that he had no mental health problems (or medication for mental illness) and had not received psychiatric treatment.

28. The man told the nurse that he had been released from prison in January 2013 and had recently taken an overdose, but he did not give any details about the circumstances of this when asked. The nurse completed a core risk assessment which is used at Dovegate to determine an individual's potential risk. The man scored 8, which was regarded as high.

29. The nurse explained to the investigator that the purpose of the initial health screen is to find out if the prisoner has any physical concerns that might need urgent attention or if they have any thoughts of self-harm or suicide. As part of the screen, he would take account of their feelings about coming into a new environment, their mental health, sentence and the nature of their offence if that

information was available or disclosed by the prisoner. However, he had received no PER or other information about him. He was unaware that he had been a psychiatric patient at the time of his arrest and the men had not disclosed this information during the assessment.

30. The nurse said he had considered the man's risks, including his high score in the risk assessment and that he had taken an overdose within the previous 90 days. Despite the high risk score, he did not begin ACCT procedures or take any other action as the man told him he had no thoughts of self-harm or suicide. He considered that the risks would be revisited at a secondary health screen when more information would be available. The man was allocated a cell on N wing. Nothing significant was recorded for the rest of the weekend.

31. The man's medication, including his inhaler, was taken from him when he arrived at Dovegate. The nurse explained that medications brought into prison are held in reception and then passed either to a nurse prescriber or to a doctor who would then see the prisoner and re-issue the medication. A doctor attends the prison for a few hours on Saturday to review newly-arrived prisoners. The nurse could not explain why the doctor on duty that afternoon had not seen the man, but surmised that the doctor might have left before new receptions had been processed. As there was no doctor or nurse prescriber on duty on the Sunday, he did not receive any medication that weekend. The nurse said that since the death, the process had changed. Prisoners with items such as inhalers are now allowed to keep them and they are reviewed when the item needs to be re-issued.

32. The medical record shows that on Monday 16 December, the man's probation officer, telephoned the prison. She explained to one of the mental health nurses, that the man had been an inpatient at St George's Hospital before his recall to prison and outlined the events that had led to this. She said that the GP, who had been responsible for the man's care in hospital, was concerned about his wellbeing. The mental health nurse then asked wing staff to bring the man to the healthcare unit urgently and notified another nurse from the prison mental health in-reach team bout the concerns that had been raised.

33. Two mental health nurses, agreed to jointly assess the man. Before doing so, a nurse left a message with staff at St George's Hospital, asking for further information and clarification about his assessment and treatment. There was no one available at the time who knew the man, as he had only been at the hospital for a few days, so she left a message for someone to call her back with information.

34. At the assessment with the nurses, the man presented well and said he did not feel low in mood or have any thoughts of harming himself. Both nurses asked him about the circumstances of his hospital admission and return to prison. He told them that it was a stupid mistake and he would never do it again. They spoke about his family and their ongoing issues and he spoke openly about being in hospital. He told them that he had never had any mental health problems or previous contact with mental health services.

35. One of the nurses said that the man was very negative about being diagnosed with such problems and seemed more concerned about his physical health, because he had not had his medication. He had been prescribed antipsychotic and medication for anxiety in hospital, but told the nurses that he did not want this. During the assessment, the man said that he felt as though he was having a panic attack. The nurses referred him to a GP because of his physical health problems.

36. A GP assessed the man and recorded his recent medical history and that he had been recalled to prison. He listed his existing medication as 30mg fexofenidine (an antihistamine), lansoprazole (to treat indigestion), 10mg pravastatin (to lower cholesterol) and ramipril (to treat high blood pressure). He noted that the man had not had any medication since Saturday, so he arranged for his blood pressure to be checked and prescribed some medication.

37. A member of staff at St George's Hospital returned the nurses's call and gave a detailed overview of his stay and their opinion of his difficulties. The assessment had still been in progress as he had only been at the hospital for three days before his recall to prison and he had refused medication in hospital.

38. Although the man denied having any thoughts of suicide or self-harm, both nurses considered that, because of his recent history and the ongoing assessment process, the man should be monitored under ACCT suicide and self-harm prevention procedures and a nurse opened an ACCT plan. The nurse advised the unit manager that, until an ACCT assessment and case review had taken place, she considered that staff should observe the man at least four times per hour. The unit manager decided that this would not be manageable and the man would be observed twice an hour.

39. The nurse told the investigator that she had considered this level of observations necessary as he had yet to be assessed by a multi-disciplinary team to identify necessary support. She believed that the reason for the unit manager's decision was that there were not enough staff to facilitate the level of observation that she had recommended.

40. A prison custody officer, carried out an ACCT assessment with him later that afternoon. She recorded his problems were his recall to custody due to what he described as poor behaviour by taking an overdose. He told the officer that he had served eight years in prison and, at the time of his recall, was in the last month of his licence. Family issues had triggered his recent overdose. He said that his daughter was trying to get approval from social services for her daughter to come and live with them, but this had been refused because of his criminal history. He said that he had taken the overdose because of this, as it would not be an issue if he were no longer there.

41. The man told the officer that he felt low and needed his medication. The officer noted that he appeared short of breath and required his inhaler. The man identified his family as supportive factors and told the officer that his son was also

at Dovegate and he hoped to move to the same wing as him. He denied any current thoughts of suicide and self-harm. A caremap was completed, identifying contact with the man's family and a review of his medication as key issues.

42. One of the medical team at St George's Hospital telephoned at 1.38pm, to give a nurse further information. When the man had first arrived at the hospital he was on one to one observations (understood to be the same as the Prison Service's constant supervision). A consultant had reviewed him on 12 December and found no evidence of low mood. The man had told him that he was positive about his future and that the triggers for his recent self-harm were an amalgamation of things, such as family issues and his parents' deaths while he had been in prison. He had expressed elements of paranoia, including that he thought his family were in danger and that someone was going to shoot him or them. He had denied any suicidal thoughts and hospital staff had reduced his observations to every 15 minutes.

43. The consultant had recorded that there was evidence of anxiety and the man had presented as suspicious. He had prescribed citalopram 20mg (an antidepressant), in place of the amitriptyline he had been prescribed in the community and quetiapine 150mg (an antipsychotic) for anxiety. At St George's, the man had been described as amiable, had interacted with other patients and engaged with ward activities. The consultant had planned to keep him in hospital for a period of assessment, as he felt he needed more time to assess him for psychotic symptoms.

44. A nurse made a further appointment for the man to see her and her colleague again on 19 December to continue their assessment. She asked for further information from the hospital and the man's probation officer to be faxed to the mental health team.

45. The unit manager, chaired the first case review at 2.00pm that afternoon, (16 December). It was attended by several members of staff including the mental health nurses. The record of the review in the ACCT document was very brief, but stated that the man had denied any thoughts of self-harm and regretted his actions. It was recorded that a mental health assessment was ongoing and that the man's risk of further self-harm was considered to be low.

46. The nurse recorded a more detailed account of the ACCT review in his medical records. She noted that he had presented as well kempt and appropriately dressed. He had maintained good eye contact and engaged well with everyone present. He had strongly denied any current thoughts of suicide or self-harm and had expressed plans for the future. The nurse had explained to him the reasons why they had started the ACCT procedures and he had replied that he understood but was not happy about such monitoring as he felt that it put him under pressure. The nurse reassured him of the confidentiality of the document and that its contents would not be shared, as she thought that he was concerned about other prisoners knowing that he was being monitored.

47. The nurse had also discussed the possibility of him being admitted to the healthcare unit, but he and the review team felt that he would cope better on the residential wing where he had friends and was close to his son. It was agreed that he would be observed three times an hour and continue to receive support from the mental health team. If anything changed before the next review, he could be admitted to the healthcare wing.

48. On 19 December, the mental health nurses had arranged to speak to him on his wing to gather more information for the mental health assessment. However, no prisoners were being unlocked until an issue with counting prisoners had been resolved. The nurses said they waited for an hour before they were able to have a brief conversation with him. The nurse said that the man was lying on his bed and seemed quite calm. They rescheduled the assessment for Monday 23 December.

49. On 20 December, a second ACCT case review was held and it was recorded that the man had no thoughts of self-harm and said that he had felt much better since moving to the same wing as his son. He had been eating and drinking and reported no problems. The ACCT form indicated that the caremap had been updated and reviewed, but there is no evidence of this. Although the mental health assessment had still not been completed and there was no input from the mental health team, the level of observations was reduced to two an hour.

50. The man had been prescribed various medications, but it was recorded in the ACCT document that the nurse said he had no medical issues. The nurse told the investigator that he had no recollection of attending the review or being asked for any information by telephone. The unit manager was unavailable for interview, but in a statement said that medical staff had not attended the review in person, but he had received a verbal report from the nurse, who had told him that there were no medical concerns. At the time, he was unaware of the ongoing mental health review. He said that he had invited all relevant parties to the review, including the mental health team, but had received no response. The nurse from the mental health team told the investigator that she had not been aware of the review and would have attended had she known.

51. The unit manager said that the man had denied any thoughts of self-harm, and had said that since moving to the same wing as his son, he had eaten and slept well and had no issues. He had been receiving his medication and felt much better than he had at the previous review. The unit manager said that on the information considered at the review, he and the other staff present decided to reduce his observations from three to two per hour.

52. During the night of 22 December, a security officer, checked the man at the prescribed intervals. At the start of the shift, he recorded that he was lying on the floor on top of his mattress and told the officer that it was good for his back. The officer checked again at 9.28pm and the man appeared to be asleep on his front. At 10.00pm, he was asleep on his right side. When the officer checked at 10.41pm, he noticed blood on the man's bedding. The man told him that he had

accidentally cut himself on a food tin while opening it. The officer requested medical assistance, as it was clear that the injury was significant.

53. A nurse noted that when she went into the man's cell there was blood all over the cell, on the floor as well as the walls. The man told the nurse that he had taken some tablets, but did not know what they were and that he wanted to die. The nurse examined him and found that he was cold and clammy, weak and his blood pressure was low. He had a deep cut between his thumb and first finger and also below his right big toe. Because of the seriousness of the injury and the amount of blood loss, the staff requested an ambulance. While they were waiting, they carried out a brief ACCT review and increased the level of observations to six per hour.

54. While waiting for the ambulance, The nurse treated the man's wound and gave him oxygen. The ambulance took him to Royal Derby Hospital at 11.55pm. He was escorted by two officers. Before leaving the prison the escort staff were given an emergency escort risk assessment but only the front cover was completed and there was no indication of the assessed level of risk or what restraints should be used. The Person Escort Record (PER) indicates that he was restrained by an escort chain (a length of chain consisting of a single handcuff at either end, one attached to the prisoner's wrist and the other to that of the escorting officer.)

55. After receiving treatment and stitching for his wound, the man remained in hospital overnight for observation. A hospital doctor told him that he had been lucky, but he is reported to have replied that he considered himself unlucky, as he had wanted to die. The next day, 23 December, he was examined by a hand specialist in an outpatients' clinic before he was discharged. The PER indicates that when he was taken to the clinic, staff applied double handcuffs. He returned to Dovegate at around 11.45am.

56. The mental health nurse had been told of the man's self-harm and met him in reception when he returned from hospital to review his ACCT plan and assess his general wellbeing. The nurse discussed with him his actions the previous evening. He denied that it had been an act of self-harm and claimed it was an accident while he had been opening a tin of mackerel. The nurse thought that this was inconsistent with both his presentation and the comments he had made to staff at the hospital, so she recommended that his observations should be increased to constant supervision and that he should move to the healthcare unit for further assessment. This was agreed.

57. The man moved to a safer cell in the Acute Assessment Unit (AAU) in the healthcare unit. (Safer cells are designed to minimise ligature points compared to those in standard cells.) The observation panel was larger than a standard cell door, so the view into the cell was unrestricted and the officer supervising him had a view of him from outside the door at all times. An operational manager, chaired another ACCT review, which was attended by mental health staff and the man's son also attended to support him.

58. The man was reported to be relatively calm and relaxed and engaged appropriately. He said that he had felt a lot of pressure after he had been released from prison as he had to support his family but he had no one to support him. He thought that he needed support but had felt too proud to ask. The review team encouraged him to seek support from staff and advised him of the support available, such as from Listeners and Samaritans. (Listeners are prisoners trained by the Samaritans who provide confidential emotional support for other prisoners.) His offender supervisor told him that he was currently on a standard licence recall. This meant that his probation officer would complete the relevant documents after he had been in custody for 28 days, if she intended to recommend his release.

59. The mental health nurse said that she had recommended that the man should be constantly supervised. The others considered this unnecessary but the review increased the level of observations from six to eight an hour. The man did not identify any problems contacting his family. There was some discussion about officers facilitating a telephone call but the ACCT documents indicated that he did not want his wife to know the detail of what had happened. As well as attending ACCT reviews after the man was admitted to the healthcare unit, his son was able to spend some time with him over the Christmas period.

60. On 24 December 2013, an occupational therapist, noted, “Given his recent history and denial of suicidal intent my personal opinion is that this man remains at a high level of risk toward completing suicide and needs to remain on high levels of observation”.

61. At midday on 24 December, an operational manager, conducted a case review, attended by mental health nurses and others in the healthcare unit, It was recorded that while the man presented as positive, the review team felt that this had been ‘over exaggerated’ for effect. He had maintained that the cut to his hand had been an accident but when challenged, became disgruntled and could not explain the comments that he had made to hospital staff about wanting to kill himself. The man’s son believed that his father needed support and that the cut might have been a suicide attempt.

62. The review team considered that constant supervision was still necessary until they obtained more information and fully completed the mental health assessment, which was due to continue on Friday 27 December, when a mental health nurse returned to work. The ACCT form indicated that the caremap had been reviewed and updated, but there is no evidence of any changes in the document.

63. A nurse completed a document entitled, ‘Person Centred Care Plan for Suicide and Self-Harm’. She explained that its purpose was for the healthcare staff in the inpatient unit and officers, who have no access to medical information, to have an overview of the reasons for a prisoner’s admission to the healthcare wing. The man’s plan listed the current need for support from staff and how to deliver it until the assessment planned by the mental health nurse on 27 December.

64. On 25 December, Mr Groombridge attended an ACCT case review, chaired by an operational manager and attended by a mental health nurse and the man's son. They discussed his level of observations, but did not reduce them.

65. The nurse said that the man had appeared low in mood and tearful during the review and admitted for the first time that his recent self-harm had been attempts to end his life. He apologised to his son and the review panel and told them that he felt ashamed of his actions and how they had impacted on his son and the rest of his family. The nurse felt this admission was significant as the man had previously consistently denied that he had deliberately self-harmed or tried to end his life. It was agreed that another ACCT case review would be convened immediately after the mental health assessment planned for 27 December.

66. The man's son spent time with him in the healthcare unit on Christmas Day. On 26 December, an operational manager, held a further ACCT review which was attended by a registered mental health nurse (RMN), and the safer custody manager, and a prisoner Listener, who attended at the man's request. The review was brief and noted that the mental health assessment was due to be continued the next day.

67. That day, Mr Groombridge asked a nurse whether he could move to K wing after he was discharged from the healthcare unit as there were prisoners on that wing who would help to support him and he felt that it would be beneficial for his mental health. The nurse recorded this conversation in the ACCT document for discussion at the next case review.

68. At 6.14pm on 26 December, a nurse reviewed the man as routine checks carried out earlier that day had shown that his blood pressure was raised. The nurse discussed this with other healthcare staff before assessing him. As he had a history of high blood pressure, they decided to call an ambulance so that paramedics could assess him. The nurse noted that the man's blood pressure was high at 174/108 and that his temperature was raised. He told the nurse that he felt fine but a little cold and that he had taken his blood pressure medication at around 4.30pm.

69. A paramedic first responder arrived at Dovegate at 6.45pm and, after reviewing the man, arranged for an ambulance to attend the prison to review him as his blood pressure was fluctuating and he was tachycardic (had a rapid heart rate). When the ambulance crew arrived at 7.00pm, they advised that the man should be transferred to hospital for further assessment and possible treatment. They took him to Queen's Hospital, where he was diagnosed with a urinary tract infection and an infection to the wound on his hand. The hospital prescribed antibiotics and discharged him.

70. The nurse recorded that escort staff had been arranged, but there is no other reference to the arrangements. Dovegate did not provide the risk assessment or the PER form relating to the man being taken to hospital on 26 December and

have been unable to say what happened to them. We therefore do not know what level of restraint was used.

71. He returned to the prison at 1.10am. A nurse recorded his diagnosis and that his blood pressure and temperature should be monitored. The nurse continued to check him and, at 2.39am, recorded that he said that he felt much better and had managed to sleep for a short period.

72. When a security officer, arrived for duty at around 6.30am on 27 December, she was instructed to report to the AAU to monitor a prisoner who needed constant supervision. (Security officers generally undertake tasks with little or no contact with prisoners, such as opening mail and escorting contractors.) At that time, the man and another prisoner were being constantly supervised in the unit. The security officer had been employed at Dovegate since 11 November, about six weeks earlier. She told the investigator that so far in her role as a security officer, she had worked in the visits room and the gatehouse but not in any of he residential units. She had not been trained to carry keys or have access to a radio and had had no training about ACCT procedures. She had had no previous direct contact with prisoners.

73. The security officer said that when she arrived in the unit, most of the other patients were asleep, but the man was awake. Someone had mentioned to her that he had returned from hospital, but she was unaware of the reasons. The security officer said she was initially placed outside the cell of the other prisoner on constant supervision and told, ‘just watch and record what they are doing every 15 minutes’. At around 7.30am, she was asked to supervise this man, but was given no handover or briefing about his background and why he was being constantly supervised.

74. The security officer said that the man seemed to be in a good mood and they chatted together. At one point, a nurse had unlocked him to collect some cleaning equipment and he had then spent some time cleaning his cell.

75. At 9.20am, the mental health in-reach nurse resumed the man’s mental health assessment in an office opposite his cell. She had reviewed his medical notes and was aware that while she had been away, he had attempted suicide. She questioned him about his childhood and family history, before moving on to the assessment of his mental health. She recorded that he was calm, did not appear distressed or distracted and there was no evidence of psychosis. The man said he felt that everyone would be better off without him around. When asked about current thoughts of harming himself, he appeared reluctant to provide an answer, but said that he felt really low in mood and confused - one, on a scale of one to ten. Despite these negative thoughts, he said that he was looking forward to a visit that had been booked with his wife and son.

76. The nurse recorded in the ACCT plan that the man remained a high risk of suicide and self-harm and recommended that he remain on a high level of observations. She was due to attend his ACCT review scheduled for 10.30am that morning.

77. The nurse told the investigator that she had arranged for the man to be seen by a psychiatrist on Monday 30 December, as it was clear to her that in view of his recent self-harm his condition had worsened. The intention was for the psychiatrist to assess whether he should be detained under the Mental Health Act. She said that in the event of a transfer, as a serving prisoner, he would have to be admitted to a secure hospital and could not go back to St George's.

78. The security officer said that after the assessment the man's demeanour changed and he appeared agitated and paced up and down in his cell. She asked him if he wanted to talk to her about anything, but he did not. She told him she thought he was getting stressed and suggested he should sit down and have a drink. The man then asked to be taken outside for a cigarette. The security officer consulted the duty nurse who said that as his ACCT review would be held shortly, he would have to wait until lunchtime. She explained this to the man, who was still pacing his cell. The security officer continued to try and engage him in conversation.

79. At 10.30am, about five minutes after returning to his cell, the man placed his hands in his pockets and stepped onto the edge of his bed. The beds in safer cells are moulded as part of the fabric and are about 12 inches from the floor. The security officer said that she told him to get down, but could not hear his reply. He then jumped into the air and landed face first on the floor. She immediately shouted for assistance.

80. The investigator viewed CCTV footage of the man's cell and the moment that he jumped from his bed. The Head of Operations, , and the Safer Custody Manager, had arrived in the unit a short while earlier for the man's ACCT review. When the security officer called for help, they immediately ran to the cell, which was near where they were standing. The Head of Operations said that they unlocked the door and went in immediately. The investigator viewed the CCTV recording and the time between the man jumping from the bed and the staff entering the cell was around 8-9seconds.

81. At that point, the manager did not know what had happened. Her first impression was that the man must have fainted and fallen and hit his head. The man was lying face down on the floor and she was about to move him onto his back, but the realised that from the amount of blood that was starting to pool on the floor around his head, this could make the situation worse. The Safer Custody Manager radioed a medical emergency code blue and records show that an ambulance was called automatically, at 10.33am, in response.

82. Other staff, who were waiting to participate in the ACCT review, and nurses in the outpatient department of the healthcare unit attended. A nurse turned the man over to assess him. She said it was evident that he had trauma to the right side of his head, his right eye, his ear and his nose and was losing a lot of blood. She could find no pulse. Another nurse brought an emergency bag and staff also brought an oxygen cylinder and suction pump. At around 10.33am, staff started

cardiopulmonary resuscitation (CPR) by giving chest compressions and the nurse tried to clear the mans mouth so that he could be given oxygen.

83. A manger cut the man's clothing to allow defibrillator pads to be attached and then continued with chest compressions. (A defibrillator is a life-saving device that gives the heart an electric shock in some cases of cardiac arrest.) The defibrillator checked for a shockable rhythm five times, but on each occasion found none. Nurses continued to administer CPR.

84. A prison doctor, arrived and checked the man twice between cycles of CPR. He recorded that there was no pulse or breathing and that the man's pupils were fixed. At 10.50am, the doctor instructed staff to stop the resuscitation attempts and confirmed that the man had died. An initial emergency response vehicle had just arrived at the prison, but was then stood down.

85. The Safer Custody Manager, a trained family liaison officer, and another family liaison officer, visited the man's wife to notify her of her husband's death. His wife has indicated that the notification came around 2.5 hours after her husband's death and feels that this should have happened much quicker as the family home is only a short drive from the prison. At the same time, the prison said that a manager told the man's son of his father's death. His wife was anxious to see her son at Dovegate so the family liaison officers arranged for his family to visit the prison and spend time with her son in the prison chapel, later that day.

86. The next day, the family liaison officers visited the man's wife again and explained more about the processes that would follow. They said that financial assistance was offered by the prison, in line with Prison Service guidance.

87. The safer custody team published notices informing prisoners of the man's death. They reviewed all prisoners subject to ACCT monitoring in case they had been affected by the death. They gave priority to supporting the man's son.

88. The security officer told the investigator that the prison had given her no support after the death. She said that she had been given a telephone number to ring, but several attempts to access support had been unsuccessful as the helpline was constantly engaged. When she eventually got through, someone said they would call her back but failed to do so.

89. The post-mortem report concluded that the cause of death was multiple fractures of the skull.

ISSUES

The man’s recall to prison

90. The man’s offence had been committed while he was under the influence of drugs and displaying signs of paranoia. Shortly after he was released from prison in early 2013, when he was living in probation accommodation, he failed a drug test but after that appeared to settle and moved back to live with his wife. Towards the end of November 2013, his probation officer was concerned that he was using ‘legal highs’ and appeared to be becoming paranoid again. After he took an overdose of drugs, his wife alerted his probation officer about her husband’s increasingly paranoid behaviour and that he believed he was being pursued by a gang from Liverpool. (Sometime earlier he had erected CCTV around their house and cut down trees which had impeded his outlook.) His probation officer referred him to a mental health crisis team.

91. On 7 December, the man was admitted to hospital after taking a life threatening overdose of prescribed medication. After a time in the hospital’s intensive treatment unit, he had a psychiatric assessment and was admitted to the psychiatric unit at St George’s Hospital in Stafford because of ongoing concerns about his risk to himself. He had provisional diagnoses of ‘depression/severe episode’ or ‘delusional disorder/psychotic episode’. On 13 December 2013, his hospital noted that he ‘clearly needed’ to be observed every 5-15 minutes and that he should be detained under holding provisions of the Mental Health Act 1983 if he asked to leave.

92. After he took his further overdose, the probation team was concerned that the issues surrounding it, including his continued paranoia and use of legal highs, mirrored the pattern of his behaviour that had led to his imprisonment and that his risk to the public had increased. Because he was a voluntary patient, his probation officer was concerned that he could leave the hospital at any time without appropriate safeguards. It was therefore decided, in the interests of public protection, that the man’s licence should be revoked and he should be recalled to prison. The probation officer did consult the hospital about the decision to recall him to prison and its implications for his treatment and the possibility of him being detained under Mental Health Act powers was discussed. When the police arrived at the hospital to take him to prison, he was not seen by a doctor and medically fitted for discharge and staff appear to have been unaware of the plan to detain him under the Mental Health Act in such circumstances.

93. It is a concern that hospital staff did not brief healthcare staff at the prison about the man’s risks and risk management plans when he was recalled to prison and that he was discharged from hospital without being seen or assessed by a doctor. The actions of the hospital are not within the remit of this investigation but have been the subject of a separate serious incident review which has identified learning for the hospital trust.

94. There appear to have been reasonable grounds for probation staff to be concerned about the man's risk to the public. The decision to recall him does not appear to have been taken in isolation based on information provided by the Probation Trust and there was reference to healthcare professionals who were caring for him. Although he was subsequently under the care of the NHS mental health in-reach team at the prison, he was not referred to a psychiatrist until the day of his death. He was due to be seen on 30 December. The nurse, who had assessed him, was concerned that his mental health had deteriorated and believed he needed to be seen by a psychiatrist to determine whether he should be transferred to hospital under the Mental Health Act. Effectively this would have returned him to the position he was in at the time his licence was revoked and he was recalled to prison two weeks earlier. More effective communication between professionals at St George's might have avoided this and we are aware that such findings have been made in a separate serious incident review by the hospital trust.

Medical care

95. The man had a number of prescribed medications when he arrived at Dovegate, including inhalers used as a preventative measure for asthma, which were taken from him. He did not see a doctor that day to have them re-prescribed as should have happened. As there were no doctors on duty on Sundays, a GP did not review and continue his medication until two days after he arrived. Regardless of when a prisoner arrives, it is important that there are arrangements to ensure that they have prompt access to necessary prescribed medication. We make the following recommendation:

    The Head of Healthcare should ensure that prisoners receive all necessary prescribed medication when they arrive at the prison.

Mental health provision

96. Mental health nurses began to assess the man two days after he arrived at Dovegate. During his two weeks at Dovegate, they spent a significant amount of time supporting him and assessing his mental health. They identified no specific symptoms to indicate a treatable psychiatric disorder, but they recognised that he remained at high risk of further self-harm and suicide. The clinical reviewer points out that the man tended to underplay his true feelings which made accurate assessment difficult. However, mental health staff recognised that what he said and how he behaved did not necessarily reflect his true mood and were mindful of this when deciding appropriate action.

97. A few days before his death, the mental health team had arranged for a psychiatrist to assess whether he should be referred to a secure mental hospital. This was due to take place on 30 December. We agree with the clinical reviewer that the mental health nurses, from both primary and secondary care teams,

worked well together and exhibited very good teamwork, communication, planning and record keeping.

Assessment of risk of self-harm

98. Prison Service Instruction (PSI) 64/2011, which covers safer custody procedures and PSI 74/2011 which deals with 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, previous self-harm and licence recall and mental health problems. Newly arrived prisoners are required to be interviewed in reception to assess their risk of self-harm and all staff are expected to be alert to the increased risk of suicide and self-harm posed by prisoners with known risk factors and act appropriately to address any concerns.

99. A Person Escort Record (PER) should accompany prisoners on all journeys between criminal justice agencies to communicate risk factors. It is the key tool to help ensure that information about the risks posed by prisoners transferred within the criminal justice system is always available to those responsible for their safe custody. The police did not provide a PER when they arrived at Dovegate and gave staff no relevant details about his history or the circumstances of his arrest. The probation service, which initiated his recall, did not provide any information until two days later and neither did the hospital. Therefore, officers and healthcare staff at Dovegate had little information about him when he arrived.

100. The actions of the police and hospital are outside the remit of this office, but it is of concern that significant information about the arrest of an individual in a mental health ward after a serious suicide attempt was not shared with prison staff. We make the following recommendation:

The Director should remind Staffordshire Police, South Staffordshire and Shropshire Healthcare and Staffordshire and West Midlands Probation Trust of the importance of ensuring that all known information about a prisoner's risk of suicide and self-harm is passed to the prison when a prisoner arrives.

101. The man had a number of factors that were significant indicators of risk, including, a history of deliberate self-harm, licence recall, and early days in custody. Although the nurse who assessed him when he arrived at Dovegate was not aware of the full circumstances of his recall, he knew that he had taken an overdose in the previous 90 days which was a factor in him scoring highly in the risk assessment. There is no record that he explored the circumstances of the overdose with him. The nurse said that he had considered potential risk factors, but he did not discuss this with other reception staff and decided not to begin ACCT procedures. It was not till two days later, after receiving further information from his probation officer, that ACCT procedures were started.

102. We are concerned that even without further information about the circumstances of his recall, staff took insufficient account of all the man's known risk factors when he arrived. It seems that in assessing his risk of self-harm, too much reliance was

placed on his statement that he had no such thoughts and little weight was attached to his recent self-harm, his high score on the risk assessment and other risk factors such as the fact that he had been recalled. Staff judgement is fundamental to assessing risk and relies on them using their experience and skills, as well as local and national assessment tools, to determine risk. All risk factors must be recorded, collated and considered to ensure that a prisoner's level of risk is holistically judged. 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. The failure to act upon the results also calls into question the relevance of staff completing the core risk assessment.

103. The man had a number of risk factors which should have been considered carefully in the context of suicide and self-harm, even without the PER or additional information from the police or probation service, but it is not apparent what weight, if any, was given to them. This did not affect the outcome for him as an ACCT was opened two days later once further information about his risk was received. However, it is important that reception staff should take into account all known risks and record the reasons for decisions when an ACCT is not opened for prisoners with significant risk factors. We make the following recommendation:

The Director and Head of Healthcare should ensure that reception staff identify, consider and record all the relevant risk factors of a newly-arrived prisoner and the reasons for decisions, when determining their risk of suicide or self-harm.

Management of the ACCT suicide and self-harm prevention procedures

104. On 16 December, immediately after the prison received information about the man's recent suicide attempt and his admission to St George's Hospital, the mental health team began monitoring him under the ACCT procedures.

105. Most case reviews were multi-disciplinary and included mental health staff, senior managers, offender supervisors and, latterly, his son. There was a consistent review team who knew the man and were familiar with his circumstances. There is evidence that the observations and entries in the ACCT document were completed in line with the prescribed levels on the front cover and it was appropriately updated each time his circumstances changed.

106. However, while those aspects of his management were very good and in line with national guidance, on at least two occasions the views of the mental health nurse about the level of observations necessary were rejected. Wing staff had objected to the level of observations recommended as they considered they would be difficult to fulfil because of staffing levels. We are concerned that decisions about monitoring levels were affected by resource considerations rather than the optimum level to minimise his risk of self-harm.

107. When the ACCT plan was opened, the caremap was completed detailing the immediate issues affecting him and actions to address them. At each case review, staff completed the relevant box to indicate that the caremap had been reviewed and updated. However, there is no evidence that the original caremap was ever amended or additional issues added.

108. While we are satisfied that, overall, ACCT procedures were effectively managed and to a good standard, the investigation identified some room for improvement. We make the following recommendation:

The Director should ensure that staff manage prisoners at risk of suicide or self-harm in line within national guidelines, including:

- **Revising caremaps to reflect changes in circumstances and needs.**
- **Setting observation levels appropriate to levels of risk.**

Constant supervision staff

109. PSI 64/2011 says, "… Staff members carrying out constant supervisions need to be considered competent to provide the level and quality of support designated in the CAREMAP". It lists a number of requirements for officers carrying out constant supervision, including, good interpersonal and report writing skills; the ability to convey to the person at risk that they are valued; taking responsibility for writing appropriate entries in the ACCT document; attending case reviews and providing a full verbal handover to other staff.

110. The instruction also specifies that all staff involved in constant supervision must be briefed on:

- The prisoner, their specific risks, needs and the care plan.
- Details of the Emergency Access Plan.
- General emergency procedures including location of alarm bells, summoning assistance (e.g. medical emergency response codes) and location of emergency response kits.
- How to access staff support networks."

111. The security officer, had only been employed at the prison for six weeks. During this period, she had undertaken duties such as working in the gatehouse, searching visitors, checking mail and allowing access to vehicles. She had no experience of working with prisoners, had not been trained to carry keys in order to access cells or in ACCT procedures and she had not been given a radio on 27 December when she was told to take over the constant supervision.

112. When the security officer arrived in the healthcare unit, apart from being told to write down what the man was doing or anything he said, she was not briefed in line with the requirements of the PSI. We acknowledge that she tried to engage him in conversation, but this was the first time she had ever had direct contact with

a prisoner and managers had not briefed her about his issues or risks. By allocating the security officer to carry out constant supervision without adhering to the guidance set out in PSI 64/2011, we consider that the prison demonstrated a lack of consideration for the welfare and support of both the man and the security officer. We make the following recommendation:

The Director should ensure that staff required to undertake constant supervision are appropriately trained, briefed and competent to fulfil the role, in line with PSI 64/2011.

Emergency response

113. The man was an inpatient in the healthcare unit being constantly supervised at the time he jumped off his bed. Although the security officer who was supervising him did not have a key to open his cell there were many other staff nearby and we are satisfied that there was no delay in raising the alarm, going into the cell and attempting to resuscitate him.

114. The clinical reviewer indicated that the man's death was sudden and irreversible and he considered that staff reacted promptly and appropriately during the resuscitation attempt in very difficult circumstances. He noted that the decision to stop attempting resuscitation was entirely appropriate given the injuries sustained and the lack of response to the resuscitation efforts. We agree with his view.

Notification of the man's admission to hospital

109. The man's wife was concerned that the prison did not contact her on 22 December, after he had harmed himself and was admitted to hospital overnight. Her son, who was also a prisoner at Dovegate, had told her the next morning. She said that the prison did not return her call when she contacted them to obtain information. Prison staff said they had no record of her call. Although it is unfortunate that she learned of her husband's self-harm in this way, it is understandable that as he had gone to hospital late at night and returned to the prison the next morning, there had been limited opportunity to inform her. We do not consider that the prison had a duty to inform his wife of his admission to hospital as he was not seriously ill at the time and note that at the ACCT review the next day he indicated that he did not want his wife to be told what he had done. His wife was also concerned that he had access to tin cans. Although items can be removed from prisoners who are regarded as at risk of self-harm, national instructions advise that this should be kept to a minimum and must never be automatic. We note that the man had no previous history of cutting himself and there was little reason at the time for the staff to consider this would be a danger.

Support for staff

110. As noted earlier, the security officer was a relatively new member of staff and this was the first time that she had been given a task which required direct contact with prisoners. The circumstances of the man's death would have been traumatic for

the most experienced member of staff to witness and all the more so for someone who was supervising a prisoner at risk for the first time. The security officer received no counselling or support after the emergency, even though she had asked for help. All staff involved in a traumatic incident should be offered support and PSI 64/2011 reminds governors and directors that staff affected by a death in custody may require support at any time and one more than one occasion after the event. We make the following recommendation:

The Director should ensure that all staff involved in a death or traumatic emergency incident are offered and receive appropriate support.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that prisoners receive all necessary prescribed medication when they arrive at the prison.

2. The Director should remind Staffordshire Police and Staffordshire and West Midlands Probation Trust of the importance of ensuring that all known information about a prisoner's risk of suicide and self-harm is passed to the prison when a prisoner arrives.

3. The Director and Head of Healthcare should ensure that reception staff identify, consider and record all the relevant risk factors of a newly-arrived prisoner and the reasons for decisions, when determining their risk of suicide or self-harm.

4. The Director should ensure that staff manage prisoners at risk of suicide or self-harm in line within national guidelines, including:

   - Revising caremaps to reflect changes in circumstances and needs.
   - Setting observation levels appropriate to levels of risk.

5. The Director should ensure that staff required to undertake constant supervision are appropriately trained, briefed and competent to fulfil the role, in line with PSI 64/2011.

6. The Director should ensure that all staff involved in a death or traumatic emergency incident are offered and receive appropriate support

ACTION PLAN: HMP Dovegate - 27 December 2013

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Chief Executive of Staffordshire and West Midlands Probation Trust should ensure that offenders receiving inpatient hospital treatment are not recalled to prison without consulting the clinicians responsible for their care.		Not applicable to Serco Health/HMP Dovegate. Awaiting a response from the Probation Trust.		
2	The Head of Healthcare should ensure that prisoners receive all necessary prescribed medication when they arrive at the prison.	Accepted	Reception nurses will seek advice for on-going prescriptions by either on-site G.P or by Serco – out of hours G.P service.	On-going	
3	The Director should	Accepted	A letter will be sent to Staffordshire	30th June	Director

	remind Staffordshire Police and Staffordshire and West Midlands Probation Trust of the importance of ensuring that all known information about a prisoner's risk of suicide and self-harm is passed to the prison when a prisoner arrives.		Police and Staffordshire and West Midlands Probation Trust with a copy of the recommendation to remind them of the importance of sharing information relevant to a prisoners risk	2014	
4	The Director and Head of Healthcare should ensure that reception staff identify, consider and record all the relevant risk factors of a newly-arrived prisoner and the reasons for decisions, when determining their risk of suicide or self-harm.	Accepted	All Healthcare Staff grades complete ACCT training in accordance with Serco Policy. Reception staff complete ACCT training including regular refresher training, and will review all relevant information available, consider any identified risk and take appropriate action on any newly arrived prisoners where there are concerns relating to self-harm or risk of suicide.	Completed	Healthcare Manager and Assistant Director of Security and Operations

5	The Director should ensure that staff manage prisoners at risk of suicide or self-harm in line within national guidelines, including: a)Revising caremaps to reflect changes in circumstances and needs. c)Setting observation levels appropriate to levels of risk	Accepted	All case managers will receive appropriate refresher training on the Case Management process for all ACCT reviews	30th September 2014	
6	The Director should ensure that staff required to undertake constant supervision are appropriately trained, briefed and	Accepted	All staff that are detailed to undertake the supervision of prisoners when they are on Constant Supervision to be trained in the Introduction of Safer Custody. All staff will receive a full handover from	Completed	

	competent to fulfil the role, in line with PSI 64/2011.		the person they are taking over from.		
7	The Director should ensure that all staff involved in a death or traumatic emergency incident are offered and receive appropriate support.	Accepted	An established staff support system is in place within HMP Dovegate and the member of staff is offered support. All staff involved in serious incidents are offered onsite immediate support through the care team and telephone and/or counselling via UNUM lifeworks.	Completed	