

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man at HMP Hewell,
in June 2014.**

Our Vision

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

This is the investigation report into the death of a man, who died on 19 June 2014, after he was found hanging in his cell at HMP Hewell three days earlier. He was 32 years old. I offer my condolences to the man's family and friends.

An investigator was appointed. A clinical reviewer reviewed the clinical care and treatment the man received at Hewell. Hewell cooperated fully with this investigation.

The man was remanded to Hewell on 22 March 2014, charged with serious sex offences. At court, he had stated he would kill himself if he was sent to prison, yet no one identified him as at risk of suicide and self-harm when he arrived at Hewell. As a result, he was not offered additional support. The man was due to appear at Coventry Crown Court on 27 June. On the afternoon of 16 June 2014, an officer found him hanging in his cell. Paramedics gave emergency treatment and managed to establish a pulse. Sadly, the man never regained consciousness and died in hospital.

I am very concerned that reception staff at Hewell did not identify the man as at risk of suicide and self-harm and do not appear to have considered the well documented information about his risk when he arrived. This was a serious omission. We cannot know whether a different assessment would have prevented the man's actions in June, but as is too often the case, prison staff placed too much reliance on his personal presentation, rather than his known risk factors. It is also unacceptable that the man did not have a general health assessment at Hewell, apparently because there were not enough officers to escort him. Finally, I am troubled that, in the three months that the man was at the prison, there is little evidence staff had any effective engagement with him, which might have helped them spot any warning signs about his intentions.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

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SUMMARY

1. On 22 March 2014, the man was remanded to HMP Hewell, charged with serious sex offences. He was 32 years old and this was his second time in prison. Court custody staff had recorded on a suicide and self-harm warning form that the man had said he would kill himself if he went to prison. Despite this, when the man arrived at Hewell, staff did not identify the man as at risk of suicide and self-harm and begin ACCT (Assessment, Care in Custody and Teamwork) procedures to support him.
2. The man did not have a general health assessment after he arrived at the prison, apparently because there were no officers to escort him. Over the next few months, the man saw healthcare staff several times because of an ear infection. No one identified any concerns about him. His personal officer did not make any entries in his prison record. There was little else recorded about him. On 3 June, a nurse gave the man a course of sleeping tablets, as he said he was finding it difficult to sleep before his forthcoming court appearance.
3. On 16 June, shortly before 2.00pm, an officer found the man hanging in his cell and called for emergency medical assistance. Officers and healthcare staff performed cardiopulmonary resuscitation until paramedics arrived. Paramedics transferred the man to the intensive care unit of the Alexandra Hospital, Redditch. He never regained consciousness and he remained in hospital until he died on 19 June.
4. The investigation found that the man should have been managed under ACCT procedures when he arrived in Hewell on 22 March. Healthcare staff did not request the man's community medical records. We are concerned that, because of a lack of staff, the man did not attend a general health assessment, which was a further missed opportunity to assess his risk. We are also concerned that the man had little contact with his personal officer and there was a delay calling an emergency ambulance. We make five recommendations.

THE INVESTIGATION PROCESS

5. We issued notices to staff and prisoners at Hewell inviting anyone with information to contact the investigator. No one responded.
6. The investigator visited Hewell on 23 June 2014 and obtained relevant records about the man. The investigator met the Governor and interviewed 11 members of staff in August. He asked to interview five prisoners, including the man's cellmate, but they all declined. The investigator informed the Governor of the preliminary findings of the investigation.
7. NHS England appointed a clinical reviewer to review the man's clinical care at the prison.
8. The investigator informed Her Majesty's Coroner for Worcestershire of the investigation who provided a copy of the post-mortem report. We have sent a copy of this report to the coroner.
9. One of our family liaison officers contacted the man's family to inform them about the investigation. The man's family did not have any specific issues for the investigation to take into account. The man's family received a copy of the draft report. They did not make any comments.

HMP HEWELL

10. HMP Hewell comprises two separate sites – a closed local prison (formerly HMP Blakenhurst) and an open prison known as The Grange Resettlement Unit (formerly Hewell Grange). The closed site, where the man lived, takes prisoners from courts in the West Midlands, Warwickshire and Worcestershire and holds up to 1074 men in six houseblocks. Worcestershire Health and Care NHS Trust provides 24 hour health care.

HM Inspectorate of Prisons

11. Her Majesty's Inspectorate of Prisons (HMIP) last inspected Hewell in July 2014. Inspectors were concerned about reception, first night and induction processes. Prisoners often had to wait for long periods in reception, and inspectors described the first night and induction unit as a chaotic environment where prisoners were not supported appropriately, and were not always assessed properly. Officers opened a higher number of ACCTs than at similar establishments, and the level of self-harm was also higher, although it had reduced since the previous inspection. Inspectors found that many prisoners self-harmed because their issues, such as medication or shop orders, were not being resolved.
12. At the previous inspection, in November 2012, inspectors found that not all PPO recommendations about previous deaths at the prison had been implemented. In July 2014, inspectors found that the prison was working on PPO recommendations but progress was too slow. The Inspectorate found that of 20 recommendations they had made about safety, only five had been achieved, with four partly achieved.

Independent Monitoring Board

13. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. The most recently published IMB annual report for the period ending November 2013 noted that incidents of self-harm and bullying had increased significantly and the reasons for these increases were not clear. The IMB commented that prison staff had greater awareness and vigilance about issues of self-harm and bullying after the introduction of a Safer Custody Policy in 2012. This had led to a significantly greater number of vulnerable prisoners being monitored under suicide and self-harm prevention procedures.

Assessment Care in Custody and Teamwork (ACCT)

14. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the actions of the caremap are completed.

Previous deaths at Hewell

15. We have investigated four self-inflicted deaths at Hewell since 2013, before the man's death. (There has been a further apparently self-inflicted death since.) In one of these cases, we were concerned that staff had not opened an ACCT, despite the prisoner's clear risk factors. We have made previous recommendations about the lack of personal officer contact and calling an emergency ambulance. We also identified these issues during this investigation.

KEY EVENTS

16. On 22 March 2014, the man appeared at Coventry Magistrates' Court charged with 28 serious sexual offences (against family members). He was remanded to HMP Hewell pending a hearing at Coventry Crown Court on 27 June. The man had previously spent four weeks in prison in 2001.
17. Before he left court for Hewell, a court custody officer completed a Person Escort Report (PER) and a Suicide and Self-Harm Warning (SSHW) form. These documents are intended to alert staff in all criminal justice agencies who come into contact with a prisoner, about their risk of suicide and self-harm. The man told the court custody officer that, if he went to prison, he would kill himself. The court custody officer noted this on the forms. The escort record and the suicide and self-harm warning form went with the man to Hewell.
18. When he arrived at the prison, at 1.33pm, the Supervising Officer (SO) met the man and signed the escort record and suicide warning form to record that he had received and read them. The SO told the investigator that he was aware of the contents of the escort record and the suicide warning form, but did not open an ACCT as he saw it as his job to alert other staff that a prisoner was at risk. He said he did not have enough time to interview prisoners in depth. He said that he received about five suicide warning forms a day, and he linked them to the escort record and put them in a tray for the reception officer and nurse to consider.
19. The officer saw the man to complete a cell sharing risk assessment, which is to assess the prisoner's risk of violence to others they might share a cell with. He noted that he had read the escort record. He recorded that the man had no concerns about sharing a cell but asked for a place on the houseblock for vulnerable prisoners, because of his alleged offences. The officer assessed that the man was a standard risk for cell sharing, which meant that he was suitable to share a cell. He noted that there were no immediate risks or concerns.
20. The officer said at interview that he had seen the escort record but did not read it. He did not recall seeing the suicide warning form. He said that usual practice was for the reception SO to give him the documentation, he would complete the cell sharing risk assessment and then pass the documents to the nurse in reception. The officer said that any member of staff could open an ACCT if they had concerns about a prisoner, but he did not do so.
21. Later that afternoon, the nurse saw the man for an initial health screen, which includes assessing risk of suicide and self-harm. The nurse did not sign the suicide warning form and there is no record that he saw the warning form or the escort record. The man told him that he had not seen his community GP recently and was not taking any medication. The man said that he had taken an overdose of amphetamines 18 years previously, but had no current thoughts of suicide or self-harm. The nurse recorded that the man had been charged with sexual offences, but was not withdrawn and his mood was stable. He did not record the name and address of the man's GP and did not request his community records. The nurse assessed that the man was not at increased risk for cell sharing.

22. The nurse was suspended from duties at the prison after the man's death and declined to be interviewed for this investigation.
23. An officer saw the man and completed a first night and induction plan. The man said that he had no immediate family issues and his family was aware that he was in custody. The officer recorded that the man did not have any issues about self-harm. She explained to the man how to seek help from staff, and contact the Samaritans and Listeners (prisoners trained by the Samaritans). She gave him information about the prison regime, including how to use the phone system.
24. The officer told the investigator that she had acted as a first night officer on 22 March for the first time that evening and had not undertaken that role since. She said that she had not seen the escort record or the suicide and self-harm warning form.
25. On 23 March, the man should have had a general health assessment with a nurse but he did not attend. A nurse wrote in the man's medical record that officers on the vulnerable persons' houseblock had told him that there were not enough staff on duty to take the man to the healthcare unit for his appointment. The nurse recorded that the appointment had been rebooked, but there is no evidence that this was done. The man never had a secondary health screen, which is a more in-depth health assessment than the reception health screen.
26. Between 24 March and 15 June, the man saw healthcare staff nine times. He was given general pain relief for joint pain and antibiotics for an ear infection. On 3 June, a nurse gave him a short course of sleeping tablets as he said he was not sleeping because of a forthcoming court appearance.
27. The man worked in the industries workshop and attended the bible study class on Monday afternoons. Prison records show that he did not make any phone calls and received no visits, other than a visit from his solicitor on 11 June. For reasons of client confidentiality, the man's solicitor did not disclose the details of their conversation, but told the investigator that he saw no signs that the man was at risk of suicide or self-harm and he did not mention having such thoughts.
28. A personal officer was allocated to the man. (Personal officers should get to know the prisoners they are responsible for, act as a first point of contact for any problems, help with resettlement issues and make regular entries in their records about their progress.) The personal officer did not make any entries in the man's prison record during his time at Hewell and there were none from any other officers on the houseblock. The personal officer told the investigator that personal officers are expected to make weekly entries about prisoners but said he was rarely on the man's houseblock as he was usually detailed to work elsewhere, so had not got to know him.
29. On the morning of 16 June, the man's cellmate went to court. The man went to work as usual and went back to his cell at lunchtime. The officer locked him in his cell at approximately 12.10pm. The officer told the investigator that he did not usually work on the man's houseblock and this was the first time that he had seen him. The officer said that the man appeared relaxed and was not agitated in any way.

30. At approximately 1.50pm, the officer began to open cells for prisoners to go to afternoon activities. When he arrived at the man's cell, he opened the door and found the man hanging from the toilet door, with a ligature made from bedding, around his neck. He immediately radioed a code blue emergency (which indicates a prisoner is unconscious or has respiratory problems.) (The control room log recorded this call at 1.52pm.) The officer cut the ligature and started cardiopulmonary resuscitation (CPR). Another officer arrived shortly afterwards and helped the officer with CPR. Ambulance Service records show that the prison made a 999 call at 1.54pm. The prison control room log recorded this as 1.56pm.
31. A nurse was on the houseblock when the officer found the man. She went immediately to the cell and took over the resuscitation attempt. Other members of the healthcare team arrived shortly afterwards. They used an automated external defibrillator (which monitors the heart rhythm and administers electrical shocks to restore the normal rhythm when necessary). The defibrillator found no shockable rhythm. Paramedics arrived at the cell at 2.15pm and took over the emergency treatment.
32. Paramedics gave the man two doses of adrenaline (to increase his heart rate and blood pressure). Eventually, they obtained a pulse, although the man remained unconscious. They took the man to the Alexandra Hospital, Redditch, where doctors admitted him to the intensive treatment unit and placed him on life support. Two officers accompanied the man, but did not use restraints.
33. The deputy governor, contacted the man's mother to inform her that her son was in the intensive care unit and that his family could visit whenever they wished. The deputy governor and a prison chaplain, met the man's mother at the hospital that evening.
34. An operational manager, debriefed the staff involved in the emergency response and discussed what had happened. The prison's care team supported staff. Officers and members of the chaplaincy supported prisoners who needed it. Prison staff reviewed prisoners subject to suicide and self-harm monitoring in case they had been affected by the man's actions.
35. Healthcare staff at Hewell remained in contact with staff at Alexandra Hospital. The hospital informed them that the man was in a critical condition and the prognosis for recovery was very poor. At 6.30pm on 18 June, the deputy governor and the prison chaplain went to the hospital and agreed there was no need for any escorting officers. The deputy governor and the prison chaplain met the man's family and left the hospital at 7.30pm. Later that evening, after a consultant's assessment, doctors withdrew life support. The man died at 0.05am on 19 June.
36. The prison maintained contact with the man's family and offered a contribution towards funeral expenses in line with national guidance. The deputy governor issued notices to staff and prisoners informing them that the man had died.

ISSUES

Assessment of risk and ACCT procedures

37. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service process for supporting and monitoring prisoners assessed as being at risk of harming themselves. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this risk and the extent to which staff need to monitor and supervise the prisoner.
38. The Prison Service Instruction covering safer custody, Prison Service Instruction (PSI) 64/2011, lists a number of risk factors and potential triggers for self-harm and suicide. These include early days in custody, previous self-harm, first time in custody, being charged with violent offences, especially against family members, and court appearances, especially at the start of a trial and sentencing. Staff should interview new prisoners in reception to assess their risk of suicide or self-harm. All staff should be alert to the increased risk of self-harm or suicide posed by prisoners with these risk factors and should act appropriately to address any concerns, including opening an ACCT if necessary.
39. PSI 64/2011 specifically states the following mandatory action:

“Any member of staff who receives information, including that from family members or external agencies, or observes behaviour which may indicate a risk of suicide/self-harm must open an ACCT by completing the Concern and Keep Safe form”
40. When the man arrived at Hewell on 22 March, reception officers did not appropriately assess his risk of suicide and self-harm and did not take any action to support him despite the suicide and self-harm warning form that had been completed at court and the risk identified on his escort record. The SO did not regard it as his job to open an ACCT. The officer did not appear to assess the man for risk of suicide or self-harm or take any action about the information on the escort record or the suicide and self-harm warning form, which he admitted he had not read.
41. The reception nurse did not record that he had seen the suicide and self-harm warning form or the escort record and it does not appear he did. His notes refer only to the man’s statement that he had no thoughts of suicide and self-harm. The reception nurse did not record that he had considered the man’s static risk factors when assessing his risk of suicide and self-harm.
42. PSI 74/2011, about early days in custody, sets out mandatory reception procedures and requires reception staff to examine the ‘Person Escort Record (PER) form that must accompany each new prisoner and any other available documentation ...to identify any immediate needs and risks already recorded’. Although the SO saw the suicide and self-harm warning form and the escort record, he believed that someone else would open an ACCT if it was appropriate to do so. The officer said he did not see the warning form and did not read the escort record. The reception nurse did not refer to the escort record or the warning form and neither took action on the documents. As a result, staff did not give the mans active support or help manage and reduce his

43. We consider that staff at Hewell should have opened an ACCT to support the man when he first arrived at the prison. In a thematic report about risk factors in self-inflicted deaths published in April 2014, we identified that too often assessments of risk place insufficient weight on known risk factors and too much on staff perceptions of the prisoner's behaviour and demeanour. The man had a number of factors known to increase the risk of suicide and self-harm which are identified in our thematic report and in Prison Service instructions. He had told staff at court that he would kill himself in prison, he was on remand, was newly-arrived and his alleged offence was against family members, and he had forthcoming court appearances. Although we do not know whether this would have affected the outcome for the man, the failure to open an ACCT meant that the man did not receive structured, ongoing support. We make the following recommendation:

The Governor should produce clear local guidance about procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them on arrival. In particular, this should ensure that reception and first night staff:

- **Have a clear understanding of their responsibilities and the need to share all relevant information about risk;**
- **Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms, PERs and other sources;**
- **Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.**

Personal Officer Scheme

44. The man had a nominated personal officer at Hewell, but that officer rarely worked on his houseblock and thus did not build up a relationship with him. Personal officers are allocated a specific number of cells at Hewell so that each officer is responsible for 12 prisoners. They are expected to talk to the prisoners they are responsible for, get to know them and make weekly entries in their prison case notes.
45. During the period 26 March to 15 June, there were no personal officer entries in the man's case notes and no entries from other officers about the man's welfare. There is no evidence of any management checks that would have identified that the man did not have contact with his personal officer or the lack of entries. It does not seem that any one really knew the man, except that he caused the officers 'no problems,' so it would have been difficult for the staff to identify if the man had any change in demeanour or that there was anything that was particularly troubling him at the time.
46. Inspectors noted failures in the personal officer scheme during the last inspection, and we recently made a recommendation about this issue in the investigation reports into another death at Hewell. There was little evidence

The Governor should ensure that officers have meaningful contact with every prisoner, through an effective personal officer scheme which ensures that officers get to know prisoners and identify their needs backed up by regular case history notes.

Clinical Care

47. The clinical reviewer, found that the clinical care that the man received at Hewell was not equivalent to that he could have expected to receive in the community. He found that there was no multi-disciplinary review of the man during his time in custody, and he was not referred for a mental health review despite his stated intention to kill himself in prison. The man did not see a doctor while he was at Hewell.
48. Prison Service Order (PSO) 3050, Continuity of Healthcare For Prisoners, says that efforts should be made to retrieve any information required from the prisoner's GP when they arrive. Healthcare staff at Hewell did not request the man's community medical records, which would have clarified whether he had been prescribed any medication or had failed to disclose any physical or mental health conditions. We make the following recommendation:

The Head of Healthcare should ensure that staff request a prisoner's community medical records within 48 hours of the prisoner arriving at Hewell.

49. PSO 3050 also gives a mandatory instruction that all prisoners should be offered a general health assessment in their first week in prison. This assessment should help staff to ensure that prisoners are settling in as well as providing an opportunity for further monitoring and health promotion. The man did not attend his second healthscreen on 23 March, as there were not enough officers to escort him to the healthcare unit. Although the nurse noted that the appointment was rebooked, there is no record of the man having a general health assessment. This meant that a further opportunity to engage with the man and see how he was coping with prison was missed. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all prisoners have the opportunity to have a general health assessment within a week of arrival and that such appointments are not cancelled because of a lack of escort staff.

Emergency Response

50. The officer found the man hanging in his cell shortly after 1.50pm. He immediately called a code blue. The control room called an ambulance at 1.54pm and paramedics arrived at the man's cell at 2.15pm.
51. Prison Service Instruction (PSI) 03/2013 Medical Emergency Response Codes provides guidance to staff on communicating the nature of a medical

“A representative NHS Ambulance guide for use in the community states that an ambulance should be called when there are signs of chest pain, difficulty in breathing, unconsciousness, severe loss of blood, severe burns or scalds, choking, fitting or concussion, severe allergic reactions or a suspected stroke. *This must also be the case for prisoners and therefore, in these situations when the emergency is called over the radio network an ambulance must be called immediately.*”

52. PSI 03/2013 was issued on 1 February 2013 and required all governors to have a medical emergency response code protocol based on the instruction by 28 February 2013. Hewell has such a protocol, but it is apparent from the control room log that there was a four minute delay between the code blue and staff calling an ambulance. We do not know whether this delay, albeit short, would have affected the outcome for the man. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies which:

- **Ensures staff efficiently and effectively communicate the nature of a medical emergency;**
- **Ensures staff called to the scene bring the relevant equipment.**

RECOMMENDATIONS

1. The Governor should produce clear local guidance about procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them on arrival. In particular, this should ensure that reception and first night staff:
 - Have a clear understanding of their responsibilities and the need to share all relevant information about risk;
 - Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms, PERs and other sources;
 - Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.
2. The Governor should ensure that officers have meaningful contact with every prisoner, through an effective personal officer scheme which ensures that officers get to know prisoners and identify their needs backed up by regular case history notes.
3. The Head of Healthcare should ensure that staff request a prisoner's community medical records within 48 hours of the prisoner arriving at Hewell.
4. The Governor and Head of Healthcare should ensure that all prisoners have the opportunity to have a general health assessment within a week of arrival and that such appointments are not cancelled because of a lack of escort staff.
5. The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies which:
 - Ensures staff efficiently and effectively communicate the nature of a medical emergency;
 - Ensures staff called to the scene bring the relevant equipment.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	<p>The Governor should produce clear local guidance about procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them on arrival. In particular, this should ensure that reception and first night staff:</p> <ul style="list-style-type: none"> • Have a clear understanding of their responsibilities and the need to share all relevant information about risk; • Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms, PERs and other sources; • Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent. 	Accepted	<p>Guidance to be issued regarding safer custody first night procedures and to review Safer Custody Policy.</p> <p>Refresher safer custody training will be delivered to all staff working in reception- both operational and healthcare.</p> <p>All case managers, which will include all reception Supervising Officers will receive further training to include: Understanding of their responsibilities and the need to share all relevant risk information and the recording of all know risk factors of newly arrived prisoners when determining their risk of suicide.</p>	<p>28 February 2015 Head of Residence and Safety</p>	

2	The Governor should ensure that officers have meaningful contact with every prisoner, through an effective personal officer scheme which ensures that officers get to know prisoners and identify their needs backed up by regular case history notes.	Accepted	We are committed to ensuring that prisoners are supported and their daily needs are met. This is an output in the Residential Services specification (75/2011). It is for Governors to decide how to deliver this. In some instances it can be achieved through a personal officer scheme but this is not the only solution and is not a mandatory requirement. Arrangements will vary to reflect the particular local circumstances. We will increase meaningful contact. A system of quality assuring the Pnomis case notes will be put in place. This will be managed by Residential custodial managers	31 st March 2015 Head of Residence and Safety and Head of Residential Services	
3	The Head of Healthcare should ensure that staff request a prisoner's community medical records within 48 hours of the prisoner arriving at Hewell.	Accepted	<ul style="list-style-type: none"> • Reception nurse to generate Consent to gain the GP information. • Administration Band 2 to chase up the new receptions from the night before and ensure that all GP and mental health information is requested. • Action added to the Secondary Screen Assessment to remind staff. 	Completed	
4	The Governor and Head of Healthcare should ensure that all prisoners have the opportunity to have a general health assessment within a week of arrival and that such appointments are not cancelled because of a lack of escort staff.	Accepted	A system is now in place to ensure these appointments are not missed. Healthcare managers check that all prisoners have received their health screening and this is monitored through healthcare operational meetings Monitored through assurance figures to Commissioners.	Completed	

5	<p>The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies which:</p> <ul style="list-style-type: none"> • Ensures staff efficiently and effectively communicate the nature of a medical emergency; • Ensures staff called to the scene bring the relevant equipment. 	Accepted	<p>The local procedure will be reviewed to ensure compliance with PSI 03/2013 and ensure this is communicated to all relevant staff. This will be communicated via operational order.</p>	<p>28th February 2015 Head of residence and Safety Head of healthcare</p>	
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