



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man at HMP
Durham in August 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 was found hanged in his cell at HMP Durham in August 2014. He was 49 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received in prison was undertaken. The prison cooperated fully with the investigation.

The man was convicted of sexual offences on 21 July 2014. Court staff completed a suicide and self-harm warning form to alert the prison to his risk, but reception staff either did not see it or did not act on it. A nurse, who conducted an initial health screen, did not consider that he was at risk of suicide or self-harm but there is no evidence that any other staff assessed his risk when he arrived. No one considered whether the nature of his offence meant that he should be located in the prison's vulnerable prisoners unit and there is little evidence of staff interaction with him after he arrived. The officer who found him hanged in his cell did not use the required emergency code, which meant an ambulance was not called immediately.

I am concerned that reception and first night procedures at Durham were so poor. Early days in custody are a particularly risky time and there is an urgent need for the prison to improve its arrangements for assessing the risk of suicide and self-harm for new arrivals, and any risks associated with their offence which make them particularly vulnerable. It then needs to ensure that appropriate support is put in place. I am also concerned that staff did not follow national and local emergency procedures, a matter I have raised with the prison before.

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

May 2015

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SUMMARY

1. On 21 July 2014, the man was convicted of sexual offences against a child. He had previously served time in prison, but not for many years. Court staff completed a suicide and self-harm warning form because they were worried about his response to his conviction and he said he had thoughts of harming himself. He was sent to HMP Durham. Although the warning form went with him to the prison, staff in the prison's reception said they did not see it and they did not act on the information in it or take into account separate information about his risk on his escort record. They did not consider whether he should be allocated to the prison's vulnerable prisoners unit.
2. The officer who interviewed the man as part of a first night assessment did not see his escort record or the suicide and self-harm warning form, and did not regard it as his responsibility to assess his risk. There is no record that the nurse who carried out an initial health screen saw the warning form. Although she noted his history of depression and self-harm from the escort record, she did not consider that he was a risk to himself.
3. On 24 July, the man was sentenced to 21 months in prison. A healthcare worker who saw him in reception when he returned from court did not consider he was at risk of harming himself. During the rest of his time at Durham very little is recorded about him in his prison records. Officers spoke to him about the public protection issues, but there is no record that they considered managing any risk associated with the nature of his offence while he was in prison. He had no contact with his personal officer, and there is no record that any other staff had any meaningful interaction with him.
4. One afternoon in August an officer found the man hanging by a cord attached to the top bunk in his cell. The officer called for help and she and another officer went immediately into the cell and cut the cord from around his neck. She radioed for medical help but did not use the appropriate emergency code. A manager arrived nearly two minutes later and radioed to ask for an ambulance. Nurses and officers attempted to resuscitate him until paramedics arrived. Just after 3.00pm, the paramedics pronounced him dead.
5. We are concerned that poor reception and first night procedures meant that staff did not use key information about the man's risk to inform their assessment when he arrived. There is no record that staff spoke to him about how he was settling in, or that they gave any consideration to managing the risk that might have been associated with the nature of his offence. The emergency response was not in line with national instructions and the local protocol. We make four recommendations.

THE INVESTIGATION PROCESS

6. The investigator issued notices to staff and prisoners at Durham about the investigation, inviting anyone with relevant information to contact him. No one responded.
7. The investigator obtained all relevant documents relating to the man's time in prison. He interviewed 22 members of staff at Durham and spoke to several prisoners. He informed the Governor about the initial findings of the investigation.
8. A clinical reviewer reviewed the man's clinical care at the prison for Spectrum CIC, commissioned by NHS England.
9. We informed HM Coroner for Durham of the investigation and we have sent the Coroner a copy of this report.
10. One of the Ombudsman's family liaison officers contacted the man's partner to discuss the investigation. His family raised a number of issues which they wanted the investigation to consider, including:
 - Whether concerns his barrister had raised at court about his risk of suicide had been acted on.
 - Whether a qualified mental health nurse had seen him when he arrived at Durham.
 - Whether he had been offered vulnerable prisoner status because of his offence.
 - Whether he had been bullied in prison.
11. The family received a copy of the draft report. They did not make any comments. The prison also received a copy of the draft report and the response to the recommendations has been added to the end of the report.

HMP DURHAM

12. HMP Durham is a local prison that serves the courts of Durham, Tyneside and Cumbria. It can hold approximately 1,000 men. Care UK provides primary healthcare services and Tees, Esk and Wear Valley NHS Trust provides mental health services.

Her Majesty's Inspectorate of Prisons

13. HM Inspectorate of Prisons' (HMIP) most recent inspection of Durham was in December 2013. Inspectors reported that self-harm had reduced significantly but arrangements to support prisoners in crisis were inadequate.
14. Inspectors found that first night interviews did not always focus on vulnerability or risk, were often rushed and were not always recorded on the day of arrival. They found that risk management, assessment and induction arrangements all needed to improve and focus on the care of the individual. In their survey of prisoners, inspectors found that 81% of prisoners said that they did not have a personal officer or had not met them. Inspectors concluded that the personal officer scheme had lapsed. Only 19% of prisoners said that a member of staff had checked to see how they were getting on, in the previous week. Inspectors noted that a significant number of staff did not show adequate care or support for prisoners.

Independent Monitoring Board

15. Each prison has an Independent Monitoring Board (IMB) made up of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its most recently published report, the IMB reported that the induction of new prisoners lacked substance and health screens at reception were often rushed. Suicide prevention procedures were improving.

Previous deaths

16. Since 2010, there have been five self-inflicted deaths at Durham and one related to a drug overdose. In five of the six deaths, staff did not call the correct emergency code which should have led to an ambulance being called immediately.
17. The prison issued a protocol for calling an ambulance in March 2013. This is the third time since then, that we have found that staff did not use the required radio codes in an emergency.

Assessment, care in custody and teamwork (ACCT)

18. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. Once a prisoner has been

identified as at risk, the purpose of the ACCT process is to try to determine the level of risk, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. 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. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

KEY EVENTS

19. The man had been in prison before, including serving a ten year sentence for arson in 1988. He had previously been in Durham, but his last prison sentence had been for eight weeks in 1997 and he had had no criminal convictions since 1998.
20. On 21 July 2014, the man was convicted of sexual offences against a child, committed some years previously. At 3.30pm, a court officer completed a suicide and self-harm warning form. The officer noted that he was low and withdrawn after his court appearance. He said he was not sure whether he had any thoughts of harming himself, but seemed confused. Court staff indicated that his risk was linked to his conviction. At 4.00pm, the court officer added that he had developed thoughts of self-harm.
21. Court custody staff completed the man's Person Escort Record (PER), a document which accompanies all prisoners when they move between police stations, courts and prisons. They wrote that he had committed a sexual offence, had attempted to hang himself five years before and was frightened about going to prison. His barrister told court staff that he had said he would not be around to hear his sentence the following Thursday.
22. The man arrived at Durham at 5.45pm and waited in the escort vehicle for 45 minutes. Escort staff handed over all accompanying documentation, including his suicide and self-harm warning form and the escort record. A Supervising Officer (SO) was the most senior officer working in reception that evening. He told the investigator that he did not remember the man. He said he had been asked to deal with another prisoner that evening, and a colleague had covered his reception duties, although he could not remember who that was.
23. At 6.30pm, an officer signed to confirm that the man had arrived at the prison, and confirmed receipt of the Person Escort Record from the escort officers. (The suicide and self-harm warning form is usually attached to the PER, but there is no separate signature to confirm its receipt. The warning form was with the papers we obtained from the prison so there is no doubt it was received.) The officer said he had worked in reception for just three weeks, and told the investigator that his role was only to log property. He said he would not have seen a suicide and self-harm warning form or assessed his risk of self-harm, despite the information on the PER.
24. The officer logged the man's property and started filling out the prison's first night, induction and initial assessment form. He wrongly noted that the man's offence was assault, rather than indecent assault. The man later told his family that he had not wanted to give the full details of his offence in reception as he was worried that other prisoners might hear him. Court staff had recorded his offence on the PER as indecent assault. It is not apparent who checked his warrant when he arrived, which would

have given the full details of his offence.

25. An officer interviewed the man as part of the first night procedures on the prison's induction wing. He said he could not specifically remember him, but he would have asked him the questions listed on the first night form, issued him with a pin phone number and tobacco. He said he would not have seen his escort record, but would usually see a suicide and self-harm warning form. He could not remember seeing his warning form.
26. The officer told the investigator that the first night interview often took no more than thirty seconds. He said that he would not consider whether the man was eligible for vulnerable prisoner status. The officer used an old version of the first night form which did not prompt him to ask about risk of suicide or self-harm. (There was a healthcare section with such questions, but it was left blank.) He said it was not the first night officer's role to consider whether a prisoner was at risk of suicide or self-harm, unless a nurse asked him to do so.
27. At 10.00pm, a mental health nurse signed the Person Escort Record to confirm that she had seen it. She did not sign the suicide and self-harm warning form, and told the investigator that she could not remember seeing it. Shortly before midnight, she saw the man for a first night health assessment. She noted that he had previously been in prison and was remanded to await sentencing for a sexual offence. She noted that he drank about five pints of beer a day, had harmed himself four times before, most recently five years previously, and had been treated for depression. He told her that he had no thoughts of self-harm. On the basis of what he told her and how he appeared, she did not consider him at risk of suicide or self-harm.
28. At a secondary health screen on 22 July, a doctor decided that the man should be monitored for signs of alcohol withdrawal. Nurses monitored him for 48 hours, but he had no withdrawal symptoms so did not need any treatment to relieve them.
29. On 23 July, a prison chaplain saw the man as part of the standard arrangements for new prisoners.
30. On 24 July, the man was sentenced to 21 months imprisonment at Crown Court. When he returned from court, a healthcare support worker assessed him in the prison's reception. She noted that he said that he was not bothered about the sentence. She told the investigator that she would have referred him to the mental health team or started an ACCT if she had considered that he needed more support.
31. On 28 July, an offender supervisor explained child protection procedures to the man, because he had been convicted of sexual offences against a child. The offender supervisor asked him if he wanted to apply to have contact with children. He said he did not want to for the time being, but

would discuss this with his family.

32. On Wednesday 6 August, the man was told he would be transferred to HMP Haverigg the next day, although there is no record of who told him, or what his reaction was. In the event, he did not go to Haverigg, as the prison does not take prisoners convicted of sexual offences. There is no record that anyone spoke to him about this and the offender supervisor told the investigator that prisoners whose transfers are cancelled are not usually given the reasons.
33. On 8 August, the man was moved from the induction wing to A Wing, one of the prison's main wings holding remand, convicted and sentenced prisoners. An officer was assigned to be his personal officer. She was not due to work on A Wing until 20 August so did not meet him when he arrived.
34. The man wrote frequently to his partner and spoke to her on the phone. His family visited him at the prison. None of his telephone calls gave any indication that he was thinking about suicide and his family did not raise any concerns with the prison about his state of mind.
35. On 13 August, a wing manager noted in the man's prison record that staff had warned him about an email that he had received on 6 August from someone under 18 years old. (Through a scheme which allows friends and families to send messages to prisoners by email, which are printed and given to the prisoner.) He was not allowed to have contact with children unless he applied for, and received, specific permission. When he spoke to his partner on 14 August, he said that he had been called into the wing office and warned about the emails. He asked his partner to stop the emails being sent.
36. There are no other records in the man's prison files. The investigator could not identify any staff who had meaningful contact with him during his time at Durham or who checked on how he was settling in on A Wing. The prisoner who shared a cell with him, said the man talked about his partner and children, but most of the time he read and did not speak much. The prisoner said that the man played pool with other prisoners, but did not have any particular friends on the wing. He said that the man never spoke to him about any thoughts of harming himself.

Day of the incident

37. At about 6.00am, the man's cellmate went for a court appearance. At around 12.10pm, an officer locked the man in his cell for the lunch period. The officer remembered that the man had been exchanging some items from the prison shop with another prisoner. The officer could not remember who the other prisoner was, but thought he was a wing cleaner. He said prisoners often did this, so he was not concerned.

38. The investigator identified 13 prisoners who were cleaners on A Wing at the time, and spoke to eight of them. (The others were no longer at the prison.) None of them recalled any contact with the man. The investigator could find no evidence that he was being bullied.
39. At around 2.30pm, Officer A started to unlock the cells on A Wing. When she got to the man's cell, she looked through the observation panel and saw him slumped in a sitting position beside his bed with a cord (possibly from his tracksuit bottoms) tied to the top bunk bed and around his neck. She shouted for help and, according to the radio log, an officer on another landing pressed a general alarm button at 2.34pm. She radioed for emergency healthcare assistance. Officer B was nearby and went into the cell with her.
40. Officer B supported the man, while Officer A cut the cord from around his neck. A custodial manager arrived at the cell as the officers were laying him on the floor to begin cardiopulmonary resuscitation. Officer B started chest compressions and Officer A gave rescue breaths. Officer A told the investigator that the man was cold and that she found it difficult to move his head to clear his airway. Another custodial manager arrived at the cell shortly after the first custodial manager. Nearly two minutes after the general alarm the control room was asked to call an ambulance.
41. The emergency response nurse arrived at the cell about two minutes after the alarm and radioed for all available nurses to come. She helped the officers with the resuscitation attempt. Two more nurses arrived, followed by another nurse who had collected the emergency response equipment, including a defibrillator and oxygen. The two nurses relieved the emergency response nurse and the officers giving cardiopulmonary resuscitation. They attached the defibrillator but this did not detect any shockable heart rhythm.
42. At 2.51pm, paramedics arrived and continued to try to resuscitate the man for several minutes. However, at 3.04pm, the paramedics pronounced him dead.
43. After the man's death, staff found a letter to his partner in his cell. He started writing the letter on 23 August, and added to it on 25 August. On the day of his death he wrote a further few lines, telling his partner that he had not got the strength and asked for her forgiveness.

Family Liaison

44. Two prison chaplains broke the news of the man's death to his partner at her home at around 7.00pm and offered condolences. The prison contributed to funeral expenses in line with national policy.

Support for staff and prisoners

45. Managers debriefed staff involved in the emergency response shortly afterwards. The staff said they found it helpful and that the prison's care and welfare team had given them good support.
46. Officers reviewed prisoners on open ACCTs. The man's cellmate said that prison staff had supported him well after the incident.

Post-mortem report

47. A post-mortem examination concluded that the man's death was caused by hanging. Toxicology tests detected no drugs or alcohol in his blood when he died.

ISSUES

Assessing risk of suicide and self-harm

48. During the reception process, neither the reception officer at the front desk, nor a nurse signed the suicide and self-harm warning form, as they should have done, if they had seen it. The SO in reception could not remember seeing the form, or meeting the man. He thought a colleague might have taken over his reception duties for a short time, while he dealt with another matter that evening. An officer signed to confirm receipt of the Person Escort Record, but did not sign the suicide and self-harm warning form. He did not remember seeing it, and did not consider it his role to assess the man's risk of suicide and self-harm. A nurse could not remember whether she had seen the suicide and self-harm warning form. The fact that she signed the escort record but not the warning form does not suggest she did.
49. There is no record that anyone in reception saw the suicide and self-harm warning form and we are very concerned that no one at Durham acted on this important information about the man's risk when he arrived. There is no evidence that anyone in reception assessed his risk, although it was only in reception that much of the information about his risk, including his offences, the information on the suicide and self-harm warning form and the Person Escort Record was available. Even without the warning form, there was significant information about his risk which appears to have either been overlooked or discounted.
50. Prison Service Instruction (PSI) 74/2011, about early days in custody, sets out mandatory reception procedures and says 'The PER and any other available documentation including Suicide & Self Harm Warning Forms, ACCT documents and CSRA assessments, must be examined, and the prisoner interviewed in Reception, to assess the risk of self-harm or harm to others by the prisoner, or harm from others'. As there is no evidence that anyone read the suicide and self-harm warning form highlighting the man's risks, we do not consider that the prison complied with this instruction.
51. An officer said that if there was a suicide and self-harm warning form, he would usually see it before completing a prisoner's first night assessment. However, he did not consider it his responsibility to consider whether a prisoner was at risk of suicide and self-harm, unless a nurse had indicated that he needed to. The officer explained to the investigator that there was no prompt question about risk of suicide or self-harm on the first night assessment form, so he did not ask prisoners about it. (The prison has revised the form, which now has several questions about risk of suicide and self-harm.) We are concerned that the first night officer did not consider it a key part of the first night assessment to assess a prisoner's risk of suicide or self-harm. The PSI emphasises the importance of supporting prisoners at risk of suicide or self-harm in the first 24 hours of custody.

52. It is a serious concern that processes designed to identify and address the risks of newly arrived prisoners were not followed. As a result, only the nurse recorded her assessment of the man's risk of self-harm, and that assessment was not fully informed. Prison Service Instruction (PSI) 64/2011, which covers safer custody procedures and PSI 74/2011, both list a number of risk factors and potential triggers for suicide and self-harm. He had a number of these at the time of his reception into Durham, which we consider should have alerted staff to his risk. We are concerned that no one considered his risk factors in the round.
53. We have criticised the assessment of a prisoner's risk in reception in other investigations into deaths at the prison. This investigation found the reception and first night process was wholly inadequate to assess the risk of potentially vulnerable prisoners. No one has been able to explain what happened to the suicide and self-harm warning form and why it was not taken into account. There was a lack of understanding of responsibilities and no clear managerial accountability. There is a need for clear operating procedures for reception and first night so that the risks and needs of newly arrived prisoners are identified and addressed. We make the following recommendation:

The Governor should ensure that there are effective operating procedures for reception and first night, and that all staff understand the procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular, staff should:

- **Have a clear understanding of 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 and PERs.**
- **Open an ACCT whenever a prisoner has recently self-harmed, expressed suicidal intent or has other significant risk factors.**

The man's contact with staff

54. From the man's arrival at Durham on 21 July, until his death in August, the only entries in his case history notes are about public and child protection issues relating to his offence. There is no evidence that officers had any meaningful interaction with him. There is no record that he had an induction programme in his case history, although he had lived on the induction unit for three weeks.
55. When the man moved from the induction unit to A Wing on 8 August, he was allocated a personal officer. She had no contact with him because she was only scheduled to work one shift on A Wing between 8 August and his death, and that was on a different landing.

56. Durham's personal officer scheme is outlined in a policy document dated March 2011 and requires that a personal officer meets a prisoner to explain the role and makes at least two entries a month in a prisoner's case history notes. A staff information notice issued in August 2011, requires that staff make at least one entry a week, although suggests that two entries should be expected. There is no evidence that the personal officer scheme has been updated since 2011 and HM Inspectorate of Prisons concluded at their inspection in December 2013, that the personal officer scheme had ceased to operate. There were no personal officer entries in the man's case history notes and no entries from any other officers to indicate that they had checked on his wellbeing during his first weeks at the prison, which is a particularly risky time.
57. We are concerned at the apparent lack of staff interaction with the man. Entries in his case history notes were poor and reflected the minimal contact that staff had with him. We make the following recommendation:

The Governor should ensure that officers have meaningful recorded contact with every prisoner, particularly in their early weeks at the prison. All prisoners should have a named officer who should be aware of their individual needs, who they can approach for help and who will make regular checks on their wellbeing, backed up by good quality entries in their case notes.

Location of vulnerable prisoners

58. The man had been convicted of sexual offences. Although he had been in prison several times in the past this had not been for some years. He had never been convicted of a sexual offence before. The prison uses C Wing to hold prisoners who might be at risk from other prisoners due to the nature of their offence, known as a vulnerable prisoners unit.
59. A SO told the investigator that he reviews prisoners' warrants when they arrive in reception and considers whether they need to be allocated to C Wing for their own safety. Despite being the reception supervising officer on the evening of 21 July, he did not recall seeing the man. There is no evidence that any consideration was given to locating him in the vulnerable prisoner unit, either when he arrived or subsequently.
60. The man had been in prison before and it is likely that he would have known that he could apply for vulnerable prisoner status and a move to C Wing, but he did not do so. It is possible that he did not want to be managed as a vulnerable prisoner, and hoped that the details of his offence would not be discovered. Nevertheless, prison staff have a duty of care towards prisoners and a responsibility to consider whether a prisoner would be more safely managed separately from the general prison population, if the nature of their offence puts them at risk. There is no evidence that anyone discussed this with him. We make the following recommendation:

The Governor should ensure that reception and first night staff consider and discuss with newly arrived prisoners, charged with or convicted of sexual offences, whether they should be allocated to the vulnerable prisoners unit.

Emergency response

61. PSI 03/2013 requires governors to have a two code medical emergency response system based on the instruction. As is usual, Durham's local policy uses code blue to indicate an emergency when a prisoner is unconscious, or having breathing difficulties, and code red when a prisoner is bleeding. Calling an emergency code should automatically trigger the control room to call an ambulance.
62. When an officer found the man hanged in his cell she did not use the emergency code blue. She told the investigator that she was aware of the correct procedure and could not explain why she had forgotten to do so at the time. Not calling an emergency code meant that the other staff who responded were not immediately alerted to the nature of the emergency and the control room did not call an ambulance automatically.
63. It was not until a manager arrived nearly two minutes later that he asked for an ambulance. Officer B did not use a code blue either. The failure to use the appropriate emergency code is unlikely to have affected the outcome for the man, as it appears he was already dead at the time he was discovered. However, in other emergencies, a difference of minutes could be crucial. We have recommended to Durham before that the Governor should ensure staff follow the emergency protocol and it is a concern that this is still not done, even after a new protocol was issued in 2013. We consider that the prison needs to take more active steps to ensure that all staff follow the required emergency procedures. We make the following recommendation:

The Governor should make active efforts to ensure that all prison staff understand their responsibilities during medical emergencies and use the appropriate emergency code to effectively communicate the nature of the emergency and which results in an ambulance being called immediately.

Clinical review

64. The clinical reviewer concluded that the standard of healthcare the man received at Durham was broadly equivalent to that he could have expected to receive in the wider community. However, she identified some areas for improvement which the Head of Healthcare will need to address. As they were not directly related to the circumstances of his death, we do not repeat them in this report.

RECOMMENDATIONS

1. The Governor should ensure that there are effective operating procedures for reception and first night, and that all staff understand the procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular, staff should:
 - Have a clear understanding of 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 and PERs.
 - Open an ACCT whenever a prisoner has recently self-harmed, expressed suicidal intent or has other significant risk factors.
2. The Governor should ensure that officers have meaningful recorded contact with every prisoner, particularly in their early weeks at the prison. All prisoners should have a named officer who should be aware of their individual needs, who they can approach for help and who will make regular checks on their wellbeing, backed up by good quality entries in their case notes.
3. The Governor should ensure that reception and first night staff consider and discuss with newly arrived prisoners, charged with or convicted of sexual offences, whether they should be allocated to the vulnerable prisoners unit.
4. The Governor should make active efforts to ensure that all prison staff understand their responsibilities during medical emergencies and use the appropriate emergency code to effectively communicate the nature of the emergency and which results in an ambulance being called immediately.

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 ensure that there are effective operating procedures for reception and first night, and that all staff understand the procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular, staff should:</p> <ul style="list-style-type: none"> • Have a clear understanding of 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 and 	Accepted	<p>All staff working in reception, health care and the first night centre will complete the Introduction to Safer Prisons training.</p> <p>The questions asked in both reception and the first night centre will be reviewed. The emphasis will be given to the individuals intent of self-harm and suicide.</p> <p>The questions asked will be prioritised and this will be highlighted using the red, amber, green system.</p> <p>A notice to staff will be issued highlighting triggers and the need to open an ACCT when an individual has expressed suicidal intent or has other significant</p>	<p>30th June 2015</p> <p>1st April 2015</p> <p>Head of Safer Custody Immediate.</p>	

Action Plan					
No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
	<p>PERs.</p> <ul style="list-style-type: none"> Open an ACCT whenever a prisoner has recently self-harmed, expressed suicidal intent or has other significant risk factors. 		risk factors.		
2	The Governor should ensure that officers have meaningful recorded contact with every prisoner, particularly in their early weeks at the prison. All prisoners should have a named officer who should be aware of their individual needs, who they can approach for help and who will make regular checks on their wellbeing, backed up by good quality entries in their case notes.	Accepted	<p>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.</p> <p>To ensure regular contact one quality entry per month will be made on NOMIS.</p> <p>Monthly checks of NOMIS case notes will be made by the wing custodial manager. This will be a signed and check retained for audit.</p>	30 th April 2015	

Action Plan					
No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
			Random checks by Head of Residence will be completed quarterly.		
3	The Governor should ensure that reception and first night staff consider and discuss with newly arrived prisoners, charged with or convicted of sexual offences, whether they should be allocated to the vulnerable prisoners unit.	Accepted	Any prisoner who is charged or convicted of a sex offence will be asked during the reception process if they are aware of vulnerable prisoner status. If they are unsure this will then be explained to them by staff. This will clarify the options available to them. Reception questionnaires will be updated to ensure this check is evidenced	30 th April 2015	
4	The Governor should make active efforts to ensure that all prison staff understand their responsibilities during medical emergencies and use the appropriate emergency code to effectively communicate the nature of the emergency and which results in an ambulance being called immediately.	Accepted	This has been escalated to the senior management team (SMT) and is to be included in the performance meetings of all SMT members. The Governors Notice To Staff will be re-issued and bold notices explaining code red / code blue will be displayed prominently in all residential wing offices. The Head of Operations will ensure that control room staff qualify any medical emergencies to make sure the correct code is reiterated.	1 st April 2015	