PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at HMP Holme House in September 2013

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 hanging in his cell at HMP Holme House on 21 September 2013. The man was 74 years old. I offer my condolences to his family and friends.

The investigation was carried out by an investigator. A clinical reviewer reviewed the clinical care which the man received in prison. The prison cooperated fully with the investigation.

The man had never been to prison before. On 18 September, he was sentenced to 14 years in prison for sex offences against a family member, committed some years previously. Reception staff at Holme House had been warned that the man had contemplated taking his own life that morning. Despite this information, and other evident risk factors that should have alerted them to the man's risk of suicide, they did not begin Prison Service suicide and self-harm prevention procedures. The vulnerable prisoner unit, where the man should have been held, was full, so he spent most of his time alone, locked in a cell on the prison's induction wing where he was unable to participate in the regime. After just three nights in prison, the man was found hanged in his cell on the morning of 21 September. It was evident that he had been dead for some time.

Assessing the risk of suicide and self-harm involves balancing the prisoner's mood and behaviour against known risk factors. I am concerned that prison staff seem to have relied too much on subjective assessments of the man's presentation. Even without a suicide and self-harm warning form, which court staff had completed before the man arrived at Holme House, greater weight should have been given to his known risk factors as a newly arrived prisoner, experiencing his first time in prison and facing a very long sentence for offences against a family member.

The early days in custody are a critical time for any prisoner and I am concerned that pressure on spaces in the prison's vulnerable prisoner unit meant that the man had a poor introduction to prison, locked alone in a cell on a wing where he was unable to mix with the other prisoners. This can only have increased his risk. HM Inspectorate Prisons recently drew attention to poor reception and induction procedures at Holme House and the prison needs to take remedial action to ensure that all new arrivals at the prison are well supported in the first few days.

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

CONTENTS

Summary	5
The investigation process	6
HMP Holme House	7
Key events	9
Issues	14
Recommendations	18
Response from NOMS to the recommendations	19

SUMMARY

1. On 18 September 2013, the man was sentenced to 14 years imprisonment for sexual offences against a family member, committed some years earlier. Court staff completed a suicide and self-harm warning form because the man had told his barrister that he had intended to kill himself that morning. The man was taken to HMP Holme House. Despite the information about the man's recent plan to take his own life, none of the staff who spoke to him when he arrived assessed him as a risk of suicide and self-harm. He was therefore not monitored under Prison Service suicide and self-harm prevention procedures, known as ACCT (Assessment, Care in Custody and Teamwork.)

2. The man was classed as a vulnerable prisoner who might be at risk from other prisoners because of his offences. However, the prison's vulnerable prisoner unit was full and he was therefore given a cell in the main induction unit. As the man had to be kept separate from the general prisoner population, he spent most of his time locked in his cell alone.

3. On his first night in the prison, an officer checked the man and thought that he seemed to be settled. The next morning, 19 September, a prison chaplain spoke to him and considered him to be coping well. The man then had an individual induction session with an officer. A nurse checked him and he did not report any concerns.

4. The man spent most of the next two days in his cell. He did not have a secondary health screen which had been scheduled for the morning of 20 September. Shortly after 5.00am on the morning of 21 September, a night patrol officer found the man hanging in his cell, suspended by a bed sheet from the bunk bed. It was apparent to the officers and nurses who attended that the man had been dead for some time, so they did not attempt cardiopulmonary resuscitation.

5. We are concerned that prison staff did not identify the man's risk of suicide and begin suicide and self-harm prevention procedures. The warning form clearly described a very recent plan by the man to take his own life, yet officers and a nurse in reception did not appear to take into account his known risk factors. Instead, they based their assessments on how he appeared to them. Holme House has no local suicide prevention policy or written procedural guidance and there are no questions or prompts about suicide and self-harm on the reception interview sheet which would help staff to identify prisoners at risk.

6. The investigation has also identified concerns about the man's location. The lack of space on the vulnerable prisoner unit meant that he spent most of his time locked alone in his cell on a general prisoner wing without even the support of a cellmate. Although it would not have made a difference to the outcome in the man's case, an ambulance was not called automatically when an emergency code was used, contrary to national and local instructions. We make three recommendations for improvement.

THE INVESTIGATION PROCESS

7. Notices were issued to staff and prisoners at HMP Holme House about the investigation. No one responded.

8. The investigator visited Holme House on 26 September. He collected copies of the man's clinical and prison records and visited the induction houseblock where the man died.

9. NHS England appointed a clinical reviewer to review the man's clinical care at the prison. Her review is annexed to this report.

10. On 15 and 16 October, the investigator and the clinical reviewer interviewed nine members of staff. The investigator gave initial feedback to the Governor after the interviews and followed this up in writing. .

11. The local Coroner has been sent a copy of this report.

12. Our family liaison officer contacted the man's wife to explain the investigation process. She asked us to provide her with an account of what had happened to her husband in prison and how he had taken his own life. She wanted to know whether he was being monitored by prison staff when he died. The man's wife received a copy of the draft report and indicated that she was satisfied with the findings.

HMP HOLME HOUSE

13. Holme House is a local prison for up to 1,212 male adult prisoners. The majority of its prisoners are remanded into custody or recently convicted by courts in the local area. The prison also holds a small number of young adults, aged 18 to 21. Care UK provide health services at Holme House. Nurses are on duty 24 hours a day. There is a vulnerable prisoner unit for men, such as sex offenders, who might be at risk from the general population.

Her Majesty's Inspectorate of Prisons

14. HM Inspectorate of Prisons (HMIP) most recently inspected Holme House in August 2013. HMIP reported that the prison faced significant challenges but had made some important progress. However, inspectors were concerned that previous progress made in learning about risk indicators associated with self-inflicted deaths had not been sustained. Care for prisoners who had been assessed as at risk of suicide or self-harm was good, but inspectors found that first night assessments were inadequate and were concerned that prisoners at risk of suicide and self harm would not be identified.

15. HMIP found that there was a lack of private space in the reception area which inhibited newly arrived prisoners from disclosing sensitive information. HMIP reported that first night cells were dirty and some of the worst they had seen. There was a lack of organised support for newly arrived prisoners. Inspectors were critical that some newly arrived vulnerable prisoners were locked up for long periods on the induction unit because there was a shortage of space in the vulnerable prisoner unit.

Independent Monitoring Board

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure that prisoners are treated fairly and decently. In their 2012 annual report, the IMB noted that reception staff provided an efficient and effective service for newly-arrived prisoners. However, they were concerned about the demand for places in the vulnerable prisoner unit which had led to vulnerable prisoners being held elsewhere in Holme House.

Previous deaths

17. Four of the last five self-inflicted deaths at Holme House since November 2011 happened during the prisoner's first days in custody. Three involved men on the induction unit. After the death of a man in June 2012, two days after arriving at Holme House, we recommended that an ACCT document should be opened whenever a prisoner had recently self-harmed or expressed suicidal intent. We also recommended that all known risk factors of newly-arrived prisoners should be fully considered, including information from suicide and self-harm warning forms. The prison accepted both recommendations and communicated them to staff in a Governor's Order on 31 January 2013. We made a similar recommendation about the need to consider all risk factors after a death in July 2012.

Assessment, Care in Custody and Teamwork (ACCT)

18. 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. 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.

KEY EVENTS

Wednesday 18 September 2013

19. The man was sentenced to 14 years imprisonment at Teesside Crown Court on Wednesday 18 September 2013, after pleading guilty to sexual offences against a family member over thirty years previously. A court custody officer completed a suicide and self-harm warning form after the man told his barrister that he had gone to his garage that morning to find a rope to hang himself.

20. The man was taken from court to HMP Holme House after sentencing and arrived at about 4.40pm. He had been on bail and had never been in prison before. Two officers interviewed the man at the desk in the reception area. They told the investigator that they had offered the man the chance to talk somewhere privately but he declined. He was the only prisoner in the reception area at the time.

21. Because of the nature of the man's offences, one officer suggested that he should be kept separately from the general population for his own protection. The man agreed. This meant that the man would normally have expected to be allocated a cell in the vulnerable prisoner unit, on Houseblock 3.

22. The officer noted the suicide and self-harm warning form and asked the man about the incident. The man explained that he had gone into his garage that morning with the intention of taking his own life but could not find a rope. He said that he did not have any current suicidal thoughts. The officer told the investigator that the man had seemed nervous and scared and had a worried look in his eyes. He said that it was his first time in prison and he had not been expecting such a long sentence. His hand shook when he was writing.

23. As it was the man's first time in prison, the officers arranged for him to spend 20 minutes in a side room in the reception area with a Listener (a prisoner trained by the Samaritans to support other prisoners in distress). They told the man that he could also discuss any concerns he had with the reception nurse. The officer completed a cell sharing risk assessment and assessed the man as a standard risk to other prisoners, which meant that he would be able to share a cell.

24. The officer told the investigator that he did not begin Assessment, Care in Custody and Teamwork (ACCT) self-harm monitoring because he was satisfied on the basis of the man's mood and behaviour that he was not at risk. The other officer also told the investigator that, despite the suicide and self-harm warning form, he had no concerns at all about the man taking his own life. The officers did not discuss with each other whether to open an ACCT document.

25. The officer took the suicide and self-harm warning form to a nurse. He told her that the man seemed OK to him but that the man had had a passing thought about killing himself that morning and had then received a long sentence at court. The officer and nurse did not discuss whether to begin ACCT monitoring. The officer said he had asked the nurse if the man should go to the healthcare centre for observation (as prisoners who have received

long sentences apparently used to do at Holme House) but the nurse did not consider this was necessary.

26. At about 5.30pm, the man saw the nurse in a side room in the reception area. She read the suicide and self-harm warning form and discussed this with the man. The nurse told the investigator that the man made it clear to her that he was glad that he had not harmed himself. She recalled that he had seemed relaxed and made good eye contact with her but he had also seemed rather dazed and puzzled by his situation. The nurse considered that the man had demonstrated a typical level of anxiety for somebody arriving in prison for the first time.

27. The man told the nurse that he did not have any suicidal thoughts at that time. He said that he had a good level of support from his wife and sister-in-law. The nurse told the investigator that she had considered ACCT monitoring but decided against this after being reassured by the man's mood and behaviour.

28. The nurse booked two appointments for the man. One appointment was to see a nurse the next day as a routine precaution to check on the well-being of prisoners who receive long sentences. The other appointment was to see a nurse for a secondary health screen on the morning of 20 September.

29. When the man arrived at Holme House, the vulnerable prisoner unit on Houseblock 3 was full, so he was temporarily given a double cell by himself on the third landing of the induction unit (Houseblock 4). At the time, there were eight other vulnerable prisoners 'lodged' on Houseblock 4 who were unable to mix with the rest of the prisoners on the wing and had a separate and very restricted regime. The man and the other vulnerable prisoners had to be unlocked separately to collect their meals, which they ate in their cells.

30. As the vulnerable prisoners on Houseblock 4 had to be kept separate from the majority of prisoners on the wing, this severely limited the amount of time they could spend out of their cell. They had to be taken to Houseblock 3 for exercise (spending a short time in the open air) and association. (Association periods allow prisoners the opportunity to socialise, take a shower, make a telephone call and complete other domestic tasks.) There is no record of whether the man was ever taken to Houseblock 3 for exercise or association. The man lived alone in his double cell for the rest of his time at Holme House and did not have any activities such as education classes or a prison job to occupy him.

31. The man arrived too late on his first night to be taken to Houseblock 3 for an association period. (Evening association periods for Houseblocks 3 and 4 were held on the same alternate evenings, which were Monday and Wednesday on that particular week.) An officer checked all the newly-arrived prisoners in their cells at about 9.00pm. She spoke to the man, who appeared settled and said that he was OK.

Thursday 19 September

32. A member of the chaplaincy sees all new prisoners the morning after they arrive. At about 7.45am the next morning, the Reverend spoke to the man in his cell and told him about the support services available and gave him a

leaflet about the chaplaincy. He established that it was the man's first time in prison. The man told the Reverend that he would be able to cope. He said that he had been surprised to receive a 14 year sentence and hoped to appeal. The man said he had family support from his wife who would visit him. The Reverend asked whether the man was having any thoughts of deliberate self-harm and he said that he was not. They spent about ten minutes talking and the Reverend thought that the man seemed to be coping well and did not appear to be distressed.

33. Another officer spent about half an hour with the man in his cell that morning to give him introductory information about prison life, as the vulnerable prisoners on Houseblock 4 could not attend the general induction presentation. The officer covered issues such as how to use the emergency cell bell, prison routines and mealtimes, how to order goods from the prison shop, and how to apply to see a chaplain. Safer custody issues such as the ACCT process, the Listener scheme and how to use the Samaritans' telephone were also covered. The officer completed a second day cell sharing risk assessment and again assessed the man as a standard risk. The man did not voice any thoughts about deliberate self-harm.

34. The man filled in a request to have his wife and sister-in-law's telephone numbers added to his prison telephone account so he would be able to call them. The vetting process to authorise these numbers involved the prison's public protection unit contacting each person to check that they wanted to receive calls from the prisoner and that the prisoner would not be able to contact his victim. The man had not yet been authorised to make any calls before he died, other than the offer of a brief telephone call in reception.

35. That morning, a nurse from the Drug and Alcohol Recovery Team based on Houseblock 4, took a telephone call from the reception area asking her to check the man because he was a new prisoner who had received a long sentence. When interviewed, she could not recall who the call was from but this appears to have been as a result of the nurse's decision the previous day to have somebody check the man.

36. The nurse went to see the man, although she did not first check his medical record to see if it contained relevant information. She told the investigator that she spoke to him for about five or ten minutes and asked him how he felt about his situation. The man told the nurse that he felt OK but had only been expecting a sentence of three years. He told the nurse that he would have to sell his car. He said that he had no thoughts of self-harm. At the time, the man was writing a letter to his wife about visiting arrangements, which were important for him. The nurse found the man calm and polite and he did not cause her any concern.

37. The prison said that vulnerable prisoners on Houseblock 4 should have been offered one hour's exercise on Houseblock 3 on Thursday afternoon. There is no record that this happened or whether the man attended. There was no association period on Houseblocks 3 and 4 that evening.

Friday 20 September

38. The man was due to have a secondary health screen at 8.55am on 20 September. (Secondary screens are to allow more detailed assessments of prisoners' physical or mental health than is possible in reception and to check how they have settled.) The man's medical record shows that healthcare staff were unable to see him, although no reason was given.

39. After the man died the letter he had been writing to his wife was found in the mail box on Houseblock 4. In the letter, he apologised for the impact his conviction would have on her, explained how she could visit him and asked her to send him money. He gave no indication in the letter that he was thinking about taking his own life. (The mail box had been emptied on Friday morning and the man's letter did not leave the wing that day. It was intercepted by staff after he died, to avoid upsetting his wife in the immediate aftermath of his death.)

40. The prison said that vulnerable prisoners on Houseblock 4 would have been offered an hour's exercise on Houseblock 3 on Friday morning and an association period in the afternoon. There is no record of this or whether the man attended.

41. All prisoners were locked up at about 4.30pm, as is the routine on a Friday. The officer was working a night shift and completed a roll check at the start of her shift at about 7.30pm. She did not notice anything unusual. A nurse, Officer and a night patrol officer were also working on Houseblock 4 that night.

Saturday 21 September

42. At about 5.00am the next morning, the night patrol officer started a roll check on the third landing of Houseblock 4, moving from A wing to B wing and then to C wing. About eight minutes later, the night patrol officer opened the observation panel on the man's cell door on C wing. It was dark, so he shone his torch into the cell. He then saw the man hanging with one end of a bed sheet tied around his neck and the other end tied to the metal bunk bed frame. He had one knee on the floor and the other was off the ground.

43. At 5.08am, the night patrol officer radioed a code blue emergency, which indicates that a prisoner is unconscious or not breathing. For security reasons, prison staff do not generally carry keys at night but have a cell key in a sealed pouch for use in an emergency. The night patrol officer broke the seal on his pouch, unlocked the cell and let staff in the control room know that he was going into the cell. He cut through the bed sheet with an anti-ligature knife, lowered the man face-down to the floor and removed the sheet from around his neck.

44. Two officers and a nurse, who had all been on different landings of Houseblock 4, joined the night patrol officer as he was going into the cell. The nurse brought the code blue emergency response bag with her. (This did not contain a defibrillator, which is stored separately in the wing manager's office.)

45. The officers turned the man onto his back. He was cold and stiff, his skin and tongue were blue and his pupils were fixed and dilated. The nurse examined the man and concluded that he had died earlier that night and that it would therefore be inappropriate and futile to attempt resuscitation. Another nurse arrived soon after and supported her assessment. The orderly officer in charge of the prison and three assist orderly officers attended the wing and agreed with this decision as it was clear that the man was dead.

46. Control room staff requested an emergency ambulance at 5.11am in response to the emergency code being called. Two ambulances arrived at the prison gate at 5.21am and 5.25am respectively. The first paramedics reached the cell at 5.24am and, at 5.27am, a paramedic pronounced the man dead. The Reverend later gave the man the last rites.

47. At 7.30am the duty governor held a debrief meeting for the staff involved in the emergency. The purpose of the meeting is to check the welfare of staff. No concerns were identified. Staff checked prisoners subject to ACCT monitoring in case they had been adversely affected by the man's death.

48. The prison's safer custody manager, and the family liaison officer, visited the man's wife at 9.15am to break the news to her. The man's funeral was held on 2 October. Holme House contributed towards the cost in accordance with Prison Service guidance. The safer custody manager, family liaison officer and Governor attended the funeral.

ISSUES

Identification of risk of suicide and self-harm on arrival

49. When the man arrived at Holme House, two reception officers and a nurse saw a suicide and self-harm warning form from the court which clearly stated that the man had made a specific plan to take his own life that same morning. He had told his barrister that he had gone to his garage intending to hang himself but could not find a rope. The reception staff did not open an ACCT document in spite of this concerning information about the man's state of mind and at least three other known risk factors:

- it was the man's first time in prison,
- he had just received a long prison sentence, and
- his victim was a family member.

50. As it was his first time in prison, officers arranged for the man to spend some time with a Listener in reception, but we consider that, on the basis of the information available to the prison, ACCT monitoring should have begun when the man arrived. The clinical reviewer reaches the same conclusion in her review of the man's clinical care. We cannot know whether this would have changed the outcome, as monitoring cannot guarantee a prisoner's safety if he is determined to take his own life. However, it would have allowed appropriate supportive mechanisms to be put in place. It appears that, as happens too often, the reception officers and the nurse relied too heavily on the man's presentation during the reception process. They did not place enough emphasis on the evidence of risk, particularly the very recent disclosure of suicidal intent. We are concerned that the officers and nurse did not discuss with each other the possibility of opening an ACCT document.

51. It is also a concern that actions from previous recommendations we have made, about the need to begin ACCT monitoring when a prisoner has expressed suicidal intent and to ensure that all risk factors for newly arrived prisoners (including information from suicide and self-harm warning forms) are fully considered, do not appear to have been implemented effectively. At the August 2013 inspection, inspectors noted that while there were comprehensive action plans to implement PPO recommendations, there was insufficient monitoring and some changes, including those for identifying the risk of suicide among newly arrived prisoners, had not been sustained.

52. We welcome the fact that the Governor has now taken some action to improve the reception process. Notices outlining the most common risk factors for suicide and self-harm have been placed in the prison's reception area for officers and healthcare staff to consider each time they interview a new prisoner. The notice emphasises the significance of information on a suicide and self-harm warning form. However, it is important that managers monitor this to ensure that new procedures become fully embedded.

53. The investigation identified that fewer ACCT documents are opened in reception than might be expected in such a large local prison. Officers in reception appear to rely too heavily on nurses to decide whether to open an ACCT document, rather than taking individual responsibility for this when they receive information suggesting a prisoner is at risk. This is a particular

concern as healthcare staff may not always have access to the full range of information necessary to identify risk, for example they may not always know that a prisoner had been recalled to prison or the circumstances.

54. The officers' approach is partly the result of an out of date Induction/Resettlement Interview Sheet which wrongly suggests that it is the responsibility of healthcare staff to open an ACCT document. This document is local and was last updated in 2008 and does not include a specific question about the risk of suicide and self-harm for the reception officer to ask. Prison Service Instruction (PSI) 64/2011, the most up-to-date national instruction governing the ACCT process, requires Governors to have procedures in place to manage and support prisoners at risk of suicide and self-harm. Holme House does not have a local suicide and self-harm policy or clear written procedures for staff to follow. It is a particular concern that, other than a Governor's Order, there is no up-to-date guidance for reception staff about the need to consider and record all risks and ensure that all information is shared.

55. Prison Service Instruction (PSI) 64/2011 clearly indicates that 'the identification and management of prisoners at risk of suicide and /or self-harm is everyone's responsibility.' Reception officers are ACCT trained and should be able to identify risk and manage it appropriately. As the increased risk of suicide among newly arrived prisoners is acknowledged and evident in recent deaths at Holme House and elsewhere, it is essential that there are clear and effective procedures in prison receptions to ensure that risks are identified and managed. Ideally, the person in charge of reception each day should be responsible for reviewing all assessments and making sure that all risk factors have been considered and recorded. Ultimately, it is the responsibility of individual governors to ensure that there are effective procedures in their prisons. We make the following recommendation:

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

- **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 or expressed suicidal intent.**

Location

56. Along with a number of other vulnerable prisoners, the man was given a cell in the induction unit (Houseblock 4) as a temporary measure because there was no space in the vulnerable prisoner unit (Houseblock 3). As a result, he had a very limited regime and spent little time out of his cell. HMIP expressed their concerns about these arrangements at their latest inspection.

57. We understand from the Governor that she and her staff are making every effort to resolve this situation, but prison population pressures make this difficult. Efforts are being made to transfer vulnerable prisoners to other, more long-term establishments where they are able to complete necessary rehabilitative programmes, but unfortunately many of these prisons are also full at present. The Governor has assured us that she is continuing to attempt to reduce the pressure on Houseblock 3 and relocate some of these prisoners to another, more suitable prison.

58. The man had no access to education or employment because he had only just arrived. He could not yet telephone his family because he needed to wait for his list of contacts to be approved. He could not mix with the rest of the prisoners on his wing so he was invariably locked up for his own safety. He was unlocked each day to collect his meals to eat in his cell. Although the prison said that the man, along with other vulnerable prisoners on Houseblock 4, “would have been” offered one hour’s exercise on Thursday afternoon and Friday morning and an association period on Friday afternoon we do not know that this happened. There is no record kept of which prisoners attend these sessions so we do not know whether they happened and whether the man took part. At the inspection in August, just weeks before his death, inspectors noted that vulnerable prisoners held on Houseblock 4 were very isolated and had poor access to association and regime activities. Inspectors found that, although they were supposed to be able to access association and exercise with other vulnerable prisoners on Houseblock 3, they were not always collected for this and their regime was generally very poor.

59. The amount of time that the man spent alone in his cell is obviously a concern given the information contained on his warning form. Regrettably, because staff had not begun ACCT monitoring or identified the risk of suicide, they did not find the man a cellmate. However, even if a prisoner was not identified as a risk of suicide and self-harm on arrival, being held in such restrictive conditions would not be conducive to good mental health. It amounts almost to segregation without the safeguards that would be in place in a segregation unit such as a daily healthcare assessment of fitness and frequent checks by officers, healthcare staff and managers.

60. The present ‘overspill’ arrangements for vulnerable prisoners on Houseblock 4 do not appear to provide an acceptable regime. It is notable that we have no evidence of any interaction with the man after the nurse went to see him on Thursday morning, until he was found dead on Saturday morning. It is regrettable that a secondary health screen did not take place on Friday morning, which was a missed opportunity to identify concerns. As it is, the man appears to have been locked in his cell and effectively forgotten. We make the following recommendation:

The Governor should ensure that vulnerable prisoners for whom there is no room in the vulnerable prisoner unit have a full regime equivalent to other prisoners and are checked regularly by a nominated officer to ensure their wellbeing.

Emergency response

61. The clinical reviewer comments in her clinical review that the response to the emergency from nursing staff was swift and reasonable and their decision not to commence CPR was in line with Resuscitation Council guidelines. However, although it would not have affected the outcome in this case, the prison's incident log shows that there was a three minute gap between control room staff receiving the code blue emergency response code and then calling for an ambulance.

62. This is contrary to the instructions in PSI 03/2013 about medical emergency response codes and the Governor's Order issued to staff at Holme House on 14 March 2013. The Governor's Order instructs control room staff to request an emergency ambulance automatically when staff use an emergency code on the radio. We understand that this matter is currently the subject of an internal investigation. We make the following recommendation:

The Governor should ensure that control room staff call an ambulance immediately a medical emergency code is received.

RECOMMENDATIONS

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

    - 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 or expressed suicidal intent.

2. The Governor should ensure that vulnerable prisoners for whom there is no room in the vulnerable prisoner unit have a full regime equivalent to other prisoners and are checked regularly by a nominated officer to ensure their wellbeing.

3. The Governor should ensure that control room staff call an ambulance immediately a medical emergency code is received.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Governor should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular this should ensure that reception and first night staff: a)Have a clear understanding of responsibilities and the need to share all relevant information about risk. b)Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk	Accepted	A system of annual reminders of staff responsibility with regard to the management of self-harm warnings has been put in place. A Governors order has been circulated describing areas of risk to consider, this will be issued yearly to all staff, including those working in healthcare and Mental health. All relevant departments (Safer Custody; Health care ;Mental health; Reception; Video Link; Custody Office; Offender Management Unit; Residential; First Night Centre and Induction) have been made aware that all newly arrived prisoners are at a heightened risk of suicide/self-harm. Information regarding known Risk factors is now displayed in	Complete Complete Complete	

	of suicide or self-harm, including information from suicide and self-harm warning forms and PERs. c)Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent		prominent positions throughout the Reception area. All reception staff have been made aware of their responsibility with regard to ACCT procedures and the importance of opening ACCTs for appropriate prisoners.	Complete	
2	The Governor should ensure that vulnerable prisoners for whom there is no room in the vulnerable prisoner unit have a full regime equivalent to other prisoners and are checked regularly by a nominated officer to ensure their wellbeing.	Accepted	Regional discussions are currently taking place to ensure that the allocation of vulnerable prisoners does not exceed the capacity of House Block 3. In the interim a member of staff has been made responsible each day for the welfare of prisoners who are awaiting a move to House Block 3.	Deputy Governor Steve Graham 30th June 2014 Complete	
3	The Governor should	Accepted	Governors Order 13-13 Response to		

	ensure that control room staff call an ambulance immediately a medical emergency code is received.		Medical Emergencies was issued in March 2013. Notice has been put in place in communication room instructing staff to immediately call an ambulance on receiving Code Red or Code Blue message. Governors Order 13-13 Response to Medical Emergencies was again circulated to all staff March 2014	Complete Complete Complete	