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 Swinfen Hall in March 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 Swinfen Hall in March 2014. He was 21 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received at Swinfen Hall was undertaken. The prison co-operated fully with the investigation.

The man had been released on licence from prison in November 2013, but was recalled to prison within a month for breaching his licence conditions. He was taken to HMP Hewell. In January 2013, he appears to have been persuaded to take some drugs to a prisoner at Swinfen Hall where he was transferring. Staff at Hewell found the drugs so he could not hand them over. Prisoners at Swinfen Hall then demanded that he should pay them for the lost drugs. He was moved to different wings twice in January to try to protect him, but said that the threats continued. On 31 January, he tried to hang himself. Staff rescued him and he was managed under suicide and self-harm prevention procedures. Despite his serious suicide attempt, this extra support ended after less than a week and he received no mental health support.

The man continued to report receiving threats and moved within the prison a further four times. The prison's violence reduction team considered a number of reports about bullying, but each was dealt with in isolation and did not resolve the problem. The alleged perpetrators were never challenged. He stopped attending activities as he was frightened to leave his wing. This meant he spent much of his time alone in his cell. One afternoon in March, he was found hanged in his cell. Prison staff and paramedics were unable to resuscitate him.

I do not consider that the man was appropriately supported under suicide and self-harm prevention procedures after he tried to kill himself on 31 January. The support measures ended prematurely and I am concerned that no one from the prison's mental health team assessed him after this serious suicide attempt. I am not satisfied that the prison properly investigated the threats against him, which left him feeling increasingly vulnerable. The only solution proposed each time was for him to move to a different wing which failed to protect him. This also resulted in him having a limited regime, a factor in itself known to increase the risk of suicide and self-harm.

The need to respond adequately to bullying is an issue that this office has highlighted in a number of previous investigations and thematic reports about suicides among young adults. The man had previously attempted suicide in November 2012, apparently because of bullying, and it is of great concern that the issue was not addressed more effectively at Swinfen Hall.

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 **December 2014**

CONTENTS

SUMMARY

1. The man had been released from a prison sentence in November 2013, but was recalled to prison on 3 December after breaching his licence conditions. He went to HMP Hewell before moving to HMP & YOI Swinfen Hall on 23 January 2014.

2. When he was leaving Hewell, officers found the man with a quantity of drugs which he said he had been given to pass to a prisoner at Swinfen Hall. When he arrived at Swinfen Hall and was unable to produce the drugs, he said that prisoners had threatened him and demanded £500 in payment.

3. On 31 January, an officer found the man trying to hang himself in his cell. He was still conscious and staff began Prison Service suicide and self-harm prevention procedures, known as ACCT. He said that he had tried to kill himself because he was worried about being attacked because of the debt for the missing drugs. Staff moved him to a different wing. He did not have a mental health assessment after his suicide attempt and staff ended ACCT support within a week.

4. The man did not settle well at Swinfen Hall and was found guilty of a number of disciplinary offences. He continued to say that he was being threatened about debts. Nine security or violence reduction incident reports were submitted about his fears, and he moved cells six times. On 20 March, after he refused to attend activities he told a violence reduction officer that he was also being bullied to pay for a mobile telephone that he had disposed of while holding it for someone. He said he was frightened for his life and wanted to move to B wing. The officer emailed the B wing manager but he was away from the prison for the next week. She therefore left a note for a colleague to discuss this with him when he returned. No other action was considered. He had given staff the names or nicknames of the prisoners who he alleged were threatening him on more than one occasion but no one spoke to them or investigated this further.

5. On 24 March, the man's offender supervisor told him that she would not be recommending to the Parole Board that he should be released at his next review. He accepted that he needed to some further work on his thinking skills, but told her that he was getting threats from all around the prison and was scared to leave the wing. The officer submitted a security report. He telephoned his father the next day and said that he was frightened because of the threats he had received. The call was monitored and reported to safer custody staff but they took no action.

6. A few days later, the man remained on his wing because of the threats against him. No one identified any other concerns about him that day but he asked a wing officer when someone from the violence reduction team would be coming to see him. The officer did not know and made no further enquiry. He was locked in his cell during the afternoon and did not alert staff to any concerns.

7. Shortly after 5.00pm, a prisoner coming back from work looked into the man's cell and saw him hanging from a bed sheet attached to his window frame. He alerted officers, who cut the ligature. An officer radioed an emergency code which should have resulted in an ambulance being called immediately, but this was not done until a manager requested one three minutes later. Officers and nurses tried to resuscitate him until paramedics arrived, but this was unsuccessful. Paramedics pronounced him dead just after 6.00pm.

8. We do not consider that the man was appropriately supported after he tried to kill himself on 31 January and are concerned that staff assessed his risk as low, the day after this serious suicide attempt. The ACCT plan was closed too early and the clinical reviewer has highlighted that he should have been referred for a mental health assessment. We are concerned that his allegations of bullying were not fully investigated. The prison's response to the threats was inadequate and failed to protect him. No one identified that his situation increased his risk of suicide and self-harm although he had previously tried to kill himself after being bullied in prison. The prison did not have an up to date emergency protocol and this resulted in a short delay in calling an ambulance after he was found hanged. We make seven recommendations.

THE INVESTIGATION PROCESS

9. The investigator issued notices to staff and prisoners at Swinfen Hall informing them of the investigation and inviting anyone with relevant information to contact him. No-one responded.

10. The investigator went to Swinfen Hall on 31 March. He spoke to prisoners who had known the man and obtained copies of his records. He later interviewed members of staff at Swinfen Hall in April and June. He was unable to speak to the prison officer who was the first member of staff to respond to the emergency as she was on long-term sick leave. He gave the Governor feedback about the preliminary findings of the investigation.

11. Shropshire & Staffordshire NHS commissioned a clinical reviewer to review the man's clinical care at the prison. The investigator and clinical reviewer interviewed healthcare staff together.

12. Staffordshire Police investigated the circumstances of the man's death but brought no charges. The officer in charge of the police investigation provided the investigator with copies of the police interviews and statements.

13. We informed HM Coroner for South Staffordshire of the investigation who provided the results of the post-mortem examination. We have sent the Coroner a copy of this report.

14. One of the Ombudsman's family liaison officers contacted the man's aunt, his next of kin, to explain our investigation and invite her to identify any issues she would like the investigation to consider. She said that a governor had told her that her nephew had highlighted his concerns about other prisoners and drug issues on a number of occasions. She asked for further information about this.

15. The man's family received a copy of the draft report. They did not make any comments.

HMP & YOI SWINFEN HALL

16. HMP & YOI Swinfen Hall holds young adult men aged 18 to 25, who are serving sentences of over four years. Swinfen Hall has recently undergone significant expansion. It has nine wings, and can hold 654 prisoners. Cells are single occupancy.

Her Majesty's Inspectorate of Prisons

17. The last published inspection report of Swinfen Hall was of an announced inspection in June 2010. At the time, inspectors found that Swinfen Hall was a reasonably safe prison with good violence-reduction arrangements, although the number of incidents of self-harm were relatively high. Bullying was evident but reporting systems were effective and the quality of investigations into alleged incidents was found to be good. The report found that the quality of self-harm monitoring documentation was reasonably good, though caremaps and post-closure interviews needed improvement. Case reviews were well-attended and multi-disciplinary.

18. The report of a more recent inspection, in June and July 2014, has yet to be published, but we understand that inspectors found that, while care for prisoners in crisis was good, the quality of case management was mixed. The recording of observations on ACCT documents was poor and case reviews were poorly-attended. The quality of ACCT post-closure reviews was poor. Inspectors found a lack of support for victims of bullying and that the formal system had fallen into disuse.

Independent Monitoring Board

19. Each prison in England and Wales has an Independent Monitoring Board (IMB) made up of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its most recent annual report for the year to April 2014, the IMB reported that there had been a rise in both the number of incidents of self-harm and ACCT documents opened at Swinfen Hall. There had been a sight reduction in the number of violent incidents.

Previous deaths at Swinfen Hall

20. We have investigated only one other self-inflicted death at Swinfen Hall since the Ombudsman's office began investigating deaths in prisons in 2004. There are no significant similarities between the circumstances of the deaths but in that investigation of a death in 2009, we also made a recommendation about post-closure interviews for prisoners who had been managed under ACCT procedures.

Assessment, Care in Custody and Teamwork (ACCT)

21. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service process for supporting and monitoring prisoners at risk of harming

themselves. The purpose of the ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should 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. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all the actions of the caremap have been completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

KEY EVENTS

22. In March 2012, the man was sentenced to four years and six months imprisonment for aggravated burglary. He had been in custody before and had previously attempted to kill himself, once because he was being bullied while he was in a young offender institution. Mental health assessments indicated that he had disabling social problems as a result of bullying and a history of self-harm, but he had not been diagnosed with a mental illness. After he was sentenced in 2012, he engaged with substance misuse teams to address his drug problems and completed a number of work courses. On 8 November 2013, he was released on licence, but did not comply with the curfew requirements of his licence and was recalled to prison. He arrived at HMP Hewell on 3 December.

23. The man told a nurse at a reception health screen that he did not have any thoughts of harming himself. The nurse did not make any record of his previous self-harm. She noted that he said that he had not received psychiatric treatment in the community. At a secondary health screen on 5 December, he said that he had never tried to kill himself when he was in the community.

24. On 23 January 2013, the man was due to transfer to HMP & YOI Swinfen Hall. As he was leaving Hewell, officers searched him and found he had four wraps of mamba (a legal high) and a quantity of tablets. He was charged with possession of unauthorised articles and was found guilty at a subsequent disciplinary hearing at Swinfen Hall on 25 January. He said that another prisoner had asked him to hold the drugs for him as he was receiving a visit and did not want to be found with them. His punishment was forfeiture of 75% of his earnings, not being allowed to order items from the canteen, not being allowed association (when prisoners are unlocked and can socialise with each other) and not being able to use the gym, all for 14 days.

25. The man's escort record noted "SH" (presumably to indicate self-harm) under the risk section, but the self-harm indicator on the front of the form was blank. At a reception health screen at Swinfen Hall, he told a nurse that he had a family history of mental health problems, and that his mother and a cousin suffered from schizophrenia. The nurse noted that he had attempted suicide while in custody in November 2012. She did not consider that there was any reason to refer him to the mental health team. He told a first night officer that he had no thoughts of suicide or self-harm and was allocated a single cell on D wing.

26. At about 11.00am on 25 January, the man rang his cell bell and told an officer that he wanted to make a telephone call. The officer told him that he would be able to make a call when prisoners were unlocked for an association period at 6.00pm. Five minutes later, he rang his cell bell again and demanded to be taken to the segregation unit. The officer said that prisoners were not segregated on request. He then threw his television set against the door, broke his kettle and damaged the toilet screen. He refused to clean up the broken glass and threatened staff. He said he was going to break his cell

windows to get moved to the segregation unit so officers moved him to B wing where the cells have plastic windows. He settled down after he had moved. He was later found guilty at a disciplinary hearing of destroying prison property.

27. On 28 January, the man attended a college and employment induction session and signed up for some education courses. The next day he moved to a cell on G wing. On 30 January, an officer introduced himself to him as his personal officer. (Personal officers are expected to 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 prisoners' records about their progress.) He said that he was happy with the move and had no issues to raise with the officer.

28. At approximately 7.30pm on 31 January, an officer saw the man hanging in his cell with a torn bed sheet around his neck attached to the top of his locker. The officer called a code blue emergency to indicate a prisoner in a life threatening situation. Staff went into the cell and cut the ligature. He was still conscious. There is no record that he received any medical treatment at the time.

29. Staff opened an ACCT plan and the initial 'Concern and Keep Safe' form noted that he was in a very low mood. The man said that he had been given the drugs found on him when he left Hewell to pass to a prisoner at Swinfen Hall. As he was not able to do so, other prisoners on the wing were demanding that he pay £250. A custodial manager completed an immediate action plan and agreed to see if he could move to another wing the next morning. He said that he would try not to harm himself again during the night. The custodial manager instructed staff to check him at least three times an hour until an ACCT assessment the next day.

30. A nurse examined the man the next morning and noted that he was tender around his neck but had no pain, no problems breathing and no other complications. He told her that he had no regrets about what he had done the night before. She told the investigator that she did not refer him to mental health services as she thought that a mental health nurse would attend his first ACCT case review later that day.

31. At 11.00am on 1 February, an officer interviewed the man for an ACCT assessment. He told her that other prisoners had threatened him with violence for losing the drugs he had been given at Hewell. He had thought that these were empty threats but the previous day he had been threatened again. He said that when he had put the ligature around his neck he had expected to die. He had tried to kill himself in 2011, when other prisoners had threatened him and told her that his mother and a cousin had both attempted suicide. He said that he got depressed, and still felt the same as he had the day before. Although he now had no specific thoughts of suicide, he could not be sure that this would remain the case. He said that he would let staff know if he got to that stage again. Other than an occasional telephone call with his father and cousin, he had little family contact and received no visits. He

agreed with her that he would try to increase his contact with his family, would speak to wing staff if he had any concerns, and that he would try to get a prison job to keep him occupied.

32. The unit manager, a Supervising Officer (SO) then held the first ACCT case review. An officer attended but there was no healthcare representation, which is a mandatory requirement for first case reviews. The man said he had no further thoughts of harming himself, and would let staff know if he did. He said he was aware of the available support networks, and would like help in addressing his emotional issues. The review assessed his risk of suicide and self-harm as low, despite his attempt to hang himself the previous day, and reduced the level of required observations to one an hour. Staff were also expected to record three quality conversations with him each day. The SO noted on an ACCT caremap that the debt issue would need to be monitored if he moved to another wing (the action for this was noted as his responsibility) and that he should advise staff if other prisoners threatened him. The review did not consider making a mental health referral despite his suicide attempt. The next review was scheduled for 6 February. The SO submitted a security report noting that he had said that the previous day three prisoners on G wing had come up to his cell door when he was locked in and threatened that he would be stabbed if he did not pay the debt because of the lost drugs.

33. On 1 February, the man was relocated to D wing. On 6 February, a SO held his second ACCT plan which a custodial manager and a nurse attended. They reviewed the issues that had been identified earlier and the caremap actions and noted that all had now been resolved. They discussed the reasons for his suicide attempt with him and how he could have dealt with it better. He said that he was happier now that he had moved wings and had made some friends on D wing. He said that he had no thoughts of harming himself and the review assessed his level of risk as low. The SO noted on the caremap that moving wing had addressed the issues about bullying and the review team decided to close the ACCT plan.

34. On 10 February, an officer introduced himself as the man's new personal officer. He recorded that he seemed to be happy on D wing and said that he wanted to make a fresh start.

35. On the morning of 13 February, a SO introduced herself to the man as his offender supervisor, responsible for his sentence planning and liaising with external probation services. She said she would visit him quarterly but if he wanted to speak to her between these times he could do so. He told her that he had no concerns.

36. Later that morning, an officer spoke to the man for an ACCT post-closure review. He said that, since he had moved wings, he no longer came into contact with the person who had been causing him problems. He said that he had little family contact, but would turn to staff or Listeners if he needed support. (Listeners are prisoners trained by the Samaritans to support other prisoners in distress.) He was working part-time, which he enjoyed, but did not go to the gym as he was trying to avoid certain prisoners. He filled out a

post-closure questionnaire which indicated that his issues had not been fully resolved as, although it had helped to move wing, away from prisoners who were threatening him, he still had to take care to avoid them.

37. That afternoon, an officer noted on the man's record that he had refused to attend work. On 22 February, an officer recorded that he had ignored a warning not to go to another prisoner's cell at lunchtime. On 25 February, she advised him that he risked losing some privileges if he got more negative comments. On the afternoon of 27 February, he barricaded himself in his cell and demanded a transfer. An officer recorded that staff persuaded him to remove the barricade but he would not assure them that he would not do it again, so the damaged furniture was removed from his cell. He was reported to have then become abusive, and smashed the observation panel in the cell door. Staff charged him with a disciplinary offence, and at a later hearing he was found guilty of damaging prison property.

38. A security report of 2 March recorded that the man said that he had held a mobile telephone for another prisoner which he had disposed of down the toilet. As a result some prisoners, whose names he did not give, were now demanding £500 from him and the prison's violence reduction team would investigate. Despite his recent move because of threats, the intelligence assessment said that he had no recent history of being a victim of bullying. On 4 March, a note on his security file said that intelligence indicated that he owed tobacco to other prisoners which he was unable to pay back. He said that he needed to get off the wing but would not give the names of the prisoners who he said were threatening him. The note said that the violence reduction team would investigate. The next day, he moved to C Wing.

39. During a routine cell search on 5 March, the man was found to have a large piece of wood hidden under his mattress. He was charged with a disciplinary offence of having an unauthorised article in his possession. A prison officer spoke to him, who said that he was being threatened with violence if he did not pay for the drugs he had lost. The incident report gives the nicknames of those he said had threatened him.

40. On 7 March, an officer from the violence reduction team spoke to the man about the intelligence report of 4 March, about tobacco debt. The officer noted that his move to C Wing seemed to have resolved the issue and no further action was required.

41. On 8 March, a disciplinary hearing, held in the segregation unit, found the man guilty of having the piece of wood in his cell. He said that it had been left over from the earlier incident when he barricaded himself in his cell and he had broken his table. As a punishment he lost 50% of his earnings for seven days, was not allowed to order any extra goods from the canteen (prison shop) for seven days, and not being allowed to attend the gym. He later told his offender supervisor that he had been concerned for his safety. After the hearing, he refused to leave the segregation unit.

42. Nurses check prisoners in the segregation each day. On 8 March, a nurse noted that she was aware that the man was concerned about his safety (because of threats from other prisoners). She recorded that he had no thoughts of self-harm or taking his own life, and that she believed his motive for staying segregated was to do with his safety. An officer completed a violence reduction incident report that day and noted that he had said he was reluctant to leave the segregation unit because he had been pressured to bring drugs to the prison (from HMP Hewell). After they had been found and he had been unable to deliver them, other prisoners were threatening to "slash him up". He was therefore refusing to move as he might be in danger.

43. At a disciplinary hearing on 8 March, the man said that he had refused to leave the segregation unit because of threats from other prisoners. He said that as well as the prisoners who were demanding recompense for the drugs they had not received, others were trying to collect the debt on their behalf. A violence reduction incident report was submitted and he was formally segregated under Prison Rule 45 for his own protection until 10 March, while the violence reduction team investigated. Staff noted that he was polite and respectful. A nurse completed an initial segregation health screen and noted that she did not consider that his mental health would deteriorate significantly if he remained segregated. There is no record that anyone considered that he was at risk of suicide and self-harm again as a result of the threats.

44. On 10 March, an officer from the violence reduction team spoke to the man. He told her that he was being pressured to pay for the drugs that had been confiscated when he left Hewell. He said that he had been offered a move to A Wing, and was content to accept that. He said that the outstanding debt had not been paid, but that if he kept a low profile on the wing he thought he would be okay. The officer told him to inform staff immediately if he encountered any problems on the wing, and signed off the incident report as completed.

45. That afternoon staff reviewed the man's continued segregation. He said that he was happy to move to A or B Wing and the review agreed he would remain in the segregation unit until a space became available on A Wing. If this took more than two days, a space would be sought on B Wing. He said that if he had any problems he would inform staff. A SO told him that she discussed arranging a sentence planning board with his offender manager (probation officer). A nurse noted in his medical record that she had seen him at the segregation review meeting and there were no signs of any mental health issues. On 11 March, a nurse saw him for a routine segregation unit check and noted that she had no concerns about his mental health.

46. On 12 March, the man moved to cell 16 on the ground floor of A Wing. On the morning of 14 March, he refused to attend work and said that he had finished the course he was taking, but did not have the documentation to confirm this. That afternoon he applied to undertake some offending behaviour courses.

47. After the man's death a prisoner on A Wing told police that on, or around, 14 March, he had told him that he was thinking of "stringing up", a prison term for hanging himself. He said that the man then laughed. He said that he should not joke about such matters and said he did not think that he was serious. He had not reported this to anyone.

48. On 15 March, an officer noted in a security report that the man had asked to speak to someone from the violence reduction team as he was being threatened because of the drug debt. On 17 March, an unsigned violence reduction incident report about this was submitted. The violence reduction team had not dealt with this by 20 March, when an officer, an officer on the team, was on his wing. An officer asked her to speak to him, as he was refusing to go to work because he was being bullied. He told her and a colleague that he was being bullied to pay for a mobile telephone that he had disposed of while holding it for someone on C wing. He said that he feared for his life and would not come out of his cell. He named some of the prisoners he said were threatening him, and said that he wanted a move to B wing. She spoke to her manager, who advised her to discuss a move with the manager of B wing, the SO. The SO was not in the prison on that day so she emailed him. No further incident report was made.

49. The next morning, 21 March, the SO replied to say that he did not think that a move to B wing was appropriate as they had several prisoners with similar difficulties and little space for new people. He said that the man should take some responsibility for his actions, and that he would meet the officer to discuss the options. The officer printed out a copy of the email and wrote on it "Can someone please speak with the SO as he's not here till Wednesday 26 and then I'm on leave for the week". She left the note in the office diary for 26 March. As the man died on 26 March, this meant that no one from the violence reduction team had spoken to the SO before he died.

50. On the morning of 24 March, a SO spoke to the man about the Parole Board's consideration of whether he was suitable for release. She said that she was concerned about his decision-making skills as he had been caught with drugs when leaving Hewell, and had adjudications (disciplinary charges) against him since he had arrived at Swinfen Hall. She said that she did not feel able to recommend his release. He agreed and said that he needed to work on his decision-making and thinking skills.

51. The man told the SO that he was getting threats from all around the prison, including some prisoners on A wing, and was scared. He felt vulnerable when moving around the prison and as a result had been refusing to attend work as it meant leaving the wing. She completed a form authorising his removal from activities and submitted a security report, giving the names or nicknames of four prisoners he said were threatening him. An officer noted on his record that although he said he was refusing to leave the wing, he continued to go from his landing to other landings at any opportunity.

52. On 25 March, the man telephoned his father and told him that he was frightened because of the threats he had received. The prison's security

department monitor a proportion of prisoners' telephone calls at random and a prison security intelligence analyst heard his call to his father. That afternoon she emailed the safer custody department to let them know that he had said that he was being threatened when moving around the prison, and that he had been threatened in the classroom when taking courses. There is no evidence that safer custody staff took any action about this.

53. The next day the man stayed on A wing because of the threats against him. During the morning he broke a pane of glass in his cell window. He told an officer and apologised and cleared up the broken glass. The officer reported the breakage for replacement. He went out to the exercise yard, and at lunchtime collected his meal from the servery. He gave no indication of any problems. Another prisoner told the police that he had spoken to him through their cell doors during the afternoon, and that he had not seemed distressed.

54. Shortly before 2.00pm, officers unlocked prisoners who were leaving the wing to go to work. The man remained locked in his cell. At about 2.05pm staff conducted a roll count of prisoners remaining on the wing. An officer checked his cell. She said that when she opened the door observation panel, he was kneeling on the floor by the door, apparently cleaning. He looked up at her and acknowledged her.

55. At approximately 2.15pm an officer said that he had passed the man's cell and noticed him sitting on the bed. He saw the officer and rang his cell bell, so the officer turned back and asked what he wanted. He asked if someone from the violence reduction team was coming to see him. The officer said that he did not know, but if paperwork had been submitted then they would do so at some point. He said that he said "Okay boss".

56. At approximately 2.55pm the prison's control room asked for another roll check as the earlier figures for the whole prison were incorrect. Two officers checked A wing together. When they got to the man's cell he was looking out of his window. He turned to look at them, but he did not speak and they did not speak to him.

57. Shortly after 5.00pm, prisoners finished work. A prisoner came back to A wing and, before being locked in his cell, wanted a cigarette paper so knocked on another prisoner's door. The other prisoner did not have any, so the prisoner went to the next cell, which was the man's. He opened the observation panel and saw him hanging by a sheet from the bed frame. He told an officer, who looked through the observation panel then immediately radioed a code blue emergency (which indicates a life-threatening situation such as when a prisoner is unconscious or has breathing difficulties). The control room log records the call at 5.13pm but they did not call an ambulance. The officer shouted to another officer for assistance and locked the prisoner in his cell. Two officers ran to the cell which the first officer opened. Two officers supported the body while another cut the sheet by which he was hanging.

58. The officers lowered the man to the floor and, as they did so, an officer thought he heard him let out a breath. He checked for signs of life and as other staff arrived, he asked someone to bring a defibrillator (a life-saving device that gives the heart an electric shock in some cases of cardiac arrest). Because he thought he had heard a breath, they laid the man in the recovery position and an officer began to check for a pulse. At this point, a nurse and a student nurse arrived, followed shortly by another nurse. The nurses took over from the officers, approximately three minutes after the emergency call.

59. A SO arrived at the cell at that point. She radioed the control room and spoke to an operational support grade to confirm that an ambulance was required. The control room log shows that she requested an ambulance at 5.16pm.

60. The nurses checked the man for signs of life but were unable to find any and began cardiopulmonary resuscitation. One nurse performed chest compressions and another administered oxygen. A SO brought a defibrillator and another SO took over chest compressions. A nurse attached the defibrillator but it did not detect any heart rhythm so the staff continued to attempt resuscitation. When a first-response paramedic arrived at 5.24pm they moved him on to the landing to allow more room and the ambulance crew arrived at 5.32pm. The paramedics continued to attempt resuscitation until 6.02pm, when they agreed that he had died.

Liaison with the man's family

61. The man had listed his aunt as his next of kin. A prison chaplain and an operational manager went to her home that evening and informed her of her nephew's death. The next morning, the prison governor telephoned to offer her condolences and support. She continued to liaise with the man's aunt and father in the following weeks. The funeral was held on 22 April. The chaplain conducted the service, at his family's request. The prison contributed to the cost of the funeral in line with Prison Service guidance.

Support for staff and prisoners

62. After the man's death a debrief was held for the staff involved in the emergency response, including the healthcare staff to ensure they had the opportunity to discuss any issues arising, and for managers to offer any necessary support. The services of the staff care team were offered.

63. Notices delivered to their cells informed prisoners of the man's death. The prisoners on his spur on A wing were moved to different cells in another area for that night. All prisoners who were being managed under ACCT procedures had their circumstances reviewed in case they had been affected by the news of his death. Some prisoners had their level of observation increased. All those who had recently been supported under ACCT procedures were also reviewed. The prison informed the local Samaritans of his death, who attended the prison to offer support.

Post-mortem report

64. A post-mortem examination on 1 April 2014, gave the cause of death as hanging.

ISSUES

Bullying

65. Swinfen Hall has a violence reduction policy, issued in May 2011. Chapter six deals with bullying and refers staff to the prison's anti-bullying strategy (which was issued in 2002). The policy says that it "seeks to ensure that perpetrators of violence are handled effectively while the victims can be identified and given appropriate levels of support". It does not identify that victims of bullying might be at increased risk of suicide or self-harm. One of the violence reduction officers explained that when violence reduction incident reports are submitted they go first to the security department and are then passed to the violence reduction team. A violence reduction officer then interviews the prisoner, investigates the problem, and responds according to the circumstances.

66. On 25 January, when the man seemed to be deliberately engineering a move to the segregation unit or another wing, no one appeared to question his motivation or investigate whether this was as a result of threats or intimidation from other prisoners. His smashing of items in his cell appears to have been regarded as poor behaviour rather than as a cry for help. It was only after he tried to hang himself on 31 January that it was established that he was being pursued for a debt he had unwittingly incurred and could not pay.

67. A security report was submitted on 1 February, after the man tried to kill himself. A further security report was submitted on 2 March, which noted that he was being bullied and that the violence reduction team was looking into the issue, but no one from his wing was investigating the allegations. Violence reduction incident reports were submitted on 4 March, on D Wing and on 7 and 8 March, after he had moved to the segregation unit. The records show that an officer from the violence reduction team saw him on 7 March in relation to the report of 4 March, but the officer noted that the problem had been resolved as he had moved from D Wing to C Wing. That day, or the following day, – records give conflicting dates – he moved to the segregation unit because he was frightened on C wing. On 15 March, a security report noted he wanted to talk to someone from the violence reduction team, and a violence reduction incident report was submitted on 17 March. This had not been dealt with by 20 March, when an officer from the team was asked to see him. A security report of 24 March, noted that he had said that he was being bullied, and on 25 March, a security analyst alerted the safer custody department that he had told his father in a telephone call that he was frightened of moving around the prison. No immediate action was taken as a result.

68. The man's records indicate that at least one of his previous suicide attempts was due to bullying. At no stage when he reported being under threat was this mentioned, even though he had discussed this in his ACCT assessment interview on 1 February. He was isolated, obviously felt unsafe and there was evidence to indicate that his concerns were genuine.

69. A PPO publication of October 2011, 'Violence reduction, bullying and safety' noted the links between bullying and violence and self-inflicted deaths of prisoners of all ages, and that these were more marked in young offender institutions. In a recent learning lessons bulletin of July 2014, in which we looked at issues arising from the self-inflicted deaths of 18 to 24 year old prisoners, we found that 20% of prisoners in our sample had experienced bullying from other prisoners in the month before their death compared to 13% of other prisoners. It is therefore concerning that the violence reduction team at Swinfen Hall and other staff responsible for managing him do not seem to have considered whether his increasing concerns about his safety exacerbated his risk of suicide and self-harm.

70. The response to the man reporting that he was under threat from other prisoners was always to move him to another part of the prison. No one ever seems to have considered whether Swinfen Hall could ever have been a safe place for him or whether he needed to move to another prison. He still felt that he could not move safely around the prison, and he was not able to attend work or education or use the gym, which meant that he spent more time locked in his cell. Each time that he said he had a problem the issue was considered in isolation. After he had attempted suicide on 31 January, because he felt under threat, prison staff managed him under ACCT procedures for just one week so he did not have effective, coordinated, ongoing support. There is no evidence that anyone discussed the links between bullying and suicide and self-harm when he reported further threats in the following weeks or that the need for further ACCT support was considered.

71. The anti-bullying strategy says that prisoners identified as bullies will be challenged. After some initial reluctance to do so, the man named those he said were threatening him. No one spoke to these prisoners, investigated the allegations against them or managed them under violence reduction procedures. Without challenging the alleged perpetrators it is difficult to see why the threats to him would be likely to stop.

72. We do not consider that the prison made sufficient attempts to resolve the man's concerns about his safety. When violence reduction reports were submitted, these did not result in meaningful action other than wing moves, even when it quickly became apparent that this would not resolve his problems. Each report was dealt with in isolation, the alleged perpetrators were not challenged and the links between bullying and suicide and self-harm were not identified and considered. We make the following recommendations:

The Governor should ensure that all information indicating bullying and intimidation is fully coordinated and investigated; that alleged perpetrators are appropriately challenged; and that apparent victims are effectively supported and protected with meaningful long term solutions, which address their individual situation.

The Governor should ensure that the impact on the risk of suicide and self-harm is always considered for apparent victims of bullying and intimidation.

73. The anti-bullying strategy was issued as a local operational instruction and was last revised in July 2002. It details the procedures to be undertaken when bullying is reported, but contains information that no longer reflects the way the system operates. It says, for example, that all incidents of bullying should be reported to the anti-bullying strategy co-ordinator, a post that no longer exists. The strategy also says that the victim will be interviewed by their wing senior officer or personal officer. This does not appear to be current process followed. The strategy refers to out-of-date systems, such as the F2052 SH system for supporting prisoners at risk of suicide and self-harm which was replaced by ACCT procedures in 2005/2006. We make the following recommendation:

The Governor should update the prison's anti-bullying strategy so that it is in line with current practice and policy and reflects the links between bullying and suicide and self-harm.

74. The violence reduction policy says that there are two violence reduction officers, providing cover during office hours Monday to Thursday, and on Friday morning. When an officer spoke to the man on 20 March (a Thursday) he said that he was scared for his life. After speaking to her manager, she sent an email to a wing manager to discuss a possible move. Because they were not in the prison at the same time, this was left for a further week, and then only with a note in the diary for someone else to pick up. We have not seen any evidence that a member of the violence reduction team spoke to the SO about this when he returned to work on the day that the man died.

75. The officer told the investigator that there was no other action that she could have taken in the SO's absence. We consider that a prisoner who felt under such threat of being harmed should not have been left for so long without any further action being taken because a single member of staff was absent. This was clearly concerning the man and, on the afternoon he died, he had asked an officer if anyone from the violence reduction team would be coming to see him but got no clear answer. It is not apparent what help the SO would have been able to offer (he appeared to be against a move to B wing) and at the time the man's welfare was a matter for the staff on A wing and the managers responsible. We consider that, rather than wait for the SO to return, the officer should have sought a solution from her manager, the SO's manager and in particular, the manager responsible for A wing, to help protect the man. We make the following recommendation:

The Governor should ensure that relevant residential managers are actively involved in decisions about the protection or prisoners in their care and that the concerns of prisoners who fear for their safety are addressed as a matter of priority.

Management of risk of suicide and self-harm

76. There are recognised factors that raise the risk of suicide and self-harm which are set out in Prison Service Instruction (PSI) 64/2011. The man had a history of self-harm, both personally and in his family. He had a history of substance misuse and had just been found in possession of drugs. He had only recently been recalled to prison. These are all recognised risks that a prisoner might be at heightened risk of suicide and self-harm. He had prison disciplinary action pending, as he had been found with drugs when he was leaving Hewell, and the risk section of his person escort record had an entry in the suicide and self-harm section indicating he was at risk. However, there is no record that staff at Swinfen Hall took these factors into consideration when assessing his risk of suicide or self-harm.

77. After the man was found hanging on 31 January, he was supported by ACCT suicide and self-harm prevention procedures. The immediate action plan and the concern and keep safe forms were filled out promptly.

78. The level of observation was set at three checks an hour, but the ACCT ongoing record up to the time of the roll count the next morning shows checks recorded only at 8.30pm, 9.30pm, 11.30pm, 2.00am, 5.00am and 7.00am. The ACCT document then shows only a further four checks before the assessment interview at 11.00am. At the first ACCT case review the level of observation was reduced to one check an hour, with three quality conversations each day. There is nothing recorded in the ACCT ongoing record between midday and 5.30pm, then nothing further until 9.00pm. Between 9.15pm that night and the 7.35am roll check, there are only four entries in the record. Throughout the period that he was being managed under ACCT procedures, the ongoing record does not reflect the number of required checks. The exception to this was the night of 4 – 5 February, when the appropriate number of checks was recorded but all were on the hour, and not at unpredictable intervals.

79. It is important that monitoring checks are completed and recorded at the required frequency if prisoners are to be properly protected and supported under ACCT procedures. It is also important that the checks are not done at predictable intervals as this allows prisoners at risk to know when the next check is likely to be and how long they are likely to have between checks if they intend to kill or harm themselves.

80. A nurse had checked the man physically before the first ACCT case review on 1 February, but she did not refer him to the mental health team because she had assumed a mental health nurse would attend the ACCT review and address any issues. There was no healthcare attendance at the review, although this is a mandatory requirement of Prison Service Instruction 64/2011, which governs ACCT procedures. At the review, he said he would like help to address his emotional issues. There is no indication on his record that he was referred for such help or received it. Although he had said at the ACCT assessment interview that he tended to get depressed, no one referred him for a mental health assessment, even after his serious suicide attempt the

night before. It is difficult to understand how this review assessed him as at low risk of suicide, less than 24 hours after he had tried to hang himself and he had said that he had no regrets about what he had done. At his ACCT assessment, just before the review, he had said he might harm himself again if his situation did not change.

81. The next ACCT review was held on the morning of 6 February. This review was multidisciplinary, in that there was a nurse present, but no one from the first review attended. We understand that the man had moved wings, but it meant that there was no continuity between ACCT reviews. The ACCT was closed that day, by staff who had little knowledge of him, less than a week after he had made a serious suicide attempt and without any mental health assessment. We consider this was premature and contributed to later problems when his risk of suicide and self-harm was not taken into account in relation to ongoing threats from other prisoners.

82. At an ACCT post-closure interview on 13 February, the man said that since he had moved wings, he no longer came into contact with the person who had been causing him problems but he was unable to go to the gym as he was trying to avoid contact with certain prisoners. He noted that this meant one aspect of his concerns had not been resolved as he had to take care to avoid certain prisoners. It is clear that he still had some fears about his safety at that time. He still did not feel able to participate fully in the prison regime, which meant he spent more time locked in his cell. There is nothing in the ACCT records to show that these issues were addressed. PSI 64/2011 has a mandatory action that, at the end of the post-closure interview, the case manager should consider whether any further reviews are necessary, and that the ACCT should be re-opened if the prisoner's risk has increased.

83. There was no clear evidence on 13 February that the man's risk of suicide or self-harm had increased since the ACCT had been closed, but it is apparent that he had continuing concerns about his safety which should have been considered. We consider it would have been appropriate to schedule another post-closure review to re-assess the situation and check whether his concern about his safety had been resolved. We make the following recommendation:

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

- **that reception staff consider and record all the known risk factors of a newly-arrived prisoner when determining risk of suicide or self-harm including information from prisoner escort records and previous prison records;**
- **that ACCT checks are made as directed, at unpredictable intervals and documented on the ongoing record;**
- **that multidisciplinary case reviews are held with a consistent case manager and include all relevant people involved in a prisoner's care;**
- **that a member of the healthcare team always attends the first ACCT review;**

- **that all risk factors, including recent suicide attempts, self-harm and bullying are fully taken into account when assessing risk; and**
- **that issues identified in post-closure ACCT reviews are properly resolved and that further post-closure reviews are held when necessary.**

Healthcare

84. The clinical reviewer noted that the man had a comprehensive reception health screen when he arrived at Swinfen Hall. Although he had a history of self-harm, there was nothing in his presentation at the time that suggested a referral to mental health services was necessary. There were no reports that he had a serious mental illness, and he had not received psychiatric care in the community.

85. We are concerned that when the man attempted to kill himself on 31 January, no one referred him to mental services. The nurse who reviewed him that morning assumed that this would be considered at the ACCT review at which someone from the mental health team would be present. As noted, this did not happen. The clinical reviewer commented that this was a missed opportunity to assess him. During his ACCT assessment, he said that he got depressed and would harm himself again if his situation did not change. This comment was not followed up. A mental health nurse attended the ACCT review at which the ACCT was closed but he had no mental health assessment after he had tried to hang himself. The clinical reviewer noted that the lack of a mental health assessment after his suicide attempt meant that the care he received at Swinfen Hall was not equivalent to that he could have expected in the community. We make the following recommendation:

The Governor and Head of Healthcare should ensure that the prisoners identified as being at risk of suicide and self-harm are referred urgently for a mental health assessment.

Emergency response

86. When a prisoner told the officer that the man was hanging, she went directly to his cell, radioed a code blue emergency and called to her colleague for help. She decided not to open the door and go into the cell alone. Prison staff have a duty of care to prisoners, but have to take into account their own safety and that of other staff. When faced with such a situation staff have to make a quick a quick dynamic risk assessment. As soon as she made the emergency call, shouted to her colleague and locked the prisoner in his cell, she opened the cell as other staff had arrived very quickly. While we consider it is usually preferable to go straight into a cell when it is clear that a prisoner's life is in danger, the delay in this case was very slight.

87. Prison Service Instruction 3/2013 (issued February 2013) requires that prisons must have a medical emergency response code protocol which ensures that an ambulance is called automatically in a life-threatening medical emergency. The protocol should give guidance on efficiently communicating

the nature of a medical emergency so that staff take the correct equipment to the incident and that there are no delays in calling an ambulance. The PSI explicitly states that all prison staff must be made aware of and understand the protocol and their responsibilities during medical emergencies. Swinfen Hall's local policy on emergency response codes is dated October 2012 and does not reflect the mandatory requirements of PSI 03/2013. An ambulance was not called automatically when the officer made the code blue call, but three minutes later, when the SO requested one. While this was not a significant delay, any delay in an emergency can be crucial. Control room staff should not have to wait for a formal request to call an ambulance one an emergency code has been received. The operational support grade who was working in the control room that day, told the investigator that she was not aware of any instructions about calling ambulances in an emergency. 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 and that Swinfen Hall has a Medical Emergency Response Code protocol which reflects the PSI and ensures that there are no delays in calling ambulances.

88. The clinical reviewer was satisfied that the medical emergency response after the man was found hanging was professional and efficient.

RECOMMENDATIONS

1. The Governor should ensure that all information indicating bullying and intimidation is fully coordinated and investigated; that alleged perpetrators are appropriately challenged; and that apparent victims are effectively supported and protected with meaningful long term solutions, which address their individual situation.

2. The Governor should ensure that the impact on the risk of suicide and self-harm is always considered for apparent victims of bullying and intimidation.

3. The Governor should update the prison's anti-bullying strategy so that it is in line with current practice and policy and reflects the links between bullying and suicide and self-harm.

4. The Governor should ensure that relevant residential managers are actively involved in decisions about the protection or prisoners in their care and that the concerns of prisoners who fear for their safety are addressed as a matter of priority.

5. The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:

    - that reception staff consider and record all the known risk factors of a newly-arrived prisoner when determining risk of suicide or self-harm including information from prisoner escort records and previous prison records;
    - that ACCT checks are made as directed, at unpredictable intervals and documented on the ongoing record;
    - that multidisciplinary case reviews are held with a consistent case manager and include all relevant people involved in a prisoner's care;
    - that a member of the healthcare team always attends the first ACCT review;
    - that all risk factors, including recent suicide attempts, self-harm and bullying are fully taken into account when assessing risk; and
    - that issues identified in post-closure ACCT reviews are properly resolved and that further post-closure reviews are held when necessary.

6. The Governor and Head of Healthcare should ensure that the prisoners identified as being at risk of suicide and self-harm are referred urgently for a mental health assessment.

7. The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Swinfen Hall has a Medical Emergency Response Code protocol which reflects the PSI and ensures that there are no delays in calling ambulances.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Governor should ensure that all information indicating bullying and intimidation is fully coordinated and investigated; that alleged perpetrators are appropriately challenged; and that apparent victims are effectively supported and protected with meaningful long term solutions, which address their individual situation.	Accepted	All information indicating bullying and intimidation is fully co-ordinated and investigated by the Safer Custody Manager. Investigations into bullying and intimidation are undertaken by the appropriate member of staff/ department. Regular liaison occurs between the investigating staff and the relevant Residential Manager. Alleged perpetrators will be appropriately challenged as per instruction and guidance contained in the updated Anti-bullying Strategy. The updated draft Anti- Bullying strategy will be published in January 2015. Support and protection will be provided to victims with meaningful long term solutions to address their individual situation by utilising the appropriate teams and resources available within the prison, for example, through use of Managers, Health Care, Mental Health Teams, Violence Reduction Team and Chaplaincy. A notice to staff explaining the procedure for the reporting of and investigation of incidents of bullying and intimidation will be re–published in January 2015. An assurance system will also be put in place to ensure compliance	Target date for completion 31.01.15 Head of Safer Custody	
2	The Governor should ensure that the impact on the risk of suicide and self-harm is always	Accepted	Prisoners experiencing bullying/intimidation will be interviewed to ascertain the risk of the prisoner self-harming or suicidal intention based on all available	Completed Head of Safer Custody	

	considered for apparent victims of bullying and intimidation.		information and the firsthand account from the apparent victim. All reported victims of apparent bullying and intimidation and those with unexplained injuries are interviewed by a member of staff. Monitoring takes place through the review of incidents and intelligence on a daily/weekly basis , and by wing staff through the Personal Officer Scheme		
3	The Governor should update the prison's anti-bullying strategy so that it is in line with current practice and policy and reflects the links between bullying and suicide and self-harm	Accepted	The Anti-Bullying Strategy (Violence Reduction policy) will be reviewed and updated to bring it into line with current practice and policy in January 2015. The updated Strategy will set out the links between bullying and self-harm / suicide. The new policy will be communicated to staff through a notice to staff, and staff briefings.	Head of Safer Custody Target date for completion:31 January 2015	
4	The Governor should ensure that relevant residential managers are actively involved in decisions about the protection of prisoners in their care and that the concerns of prisoners who fear for their safety are addressed as a matter of priority	Accepted	Safer custody procedures have been put into practice to ensure that the relevant Residential Manager attends meetings with a prisoner who has fears for their safety. Staff have been advised of the relevant Residential Manager to whom they must pass on the information regarding any concerns expressed by a prisoner regarding their safety. The Residential Manager will act on concerns by interviewing the prisoner and referring them to the appropriate team(s). All information will be recorded.	Completed Head of Residence	
5	The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including: ▪ that reception staff consider and record all the known	Accepted	Reception staff will co-ordinate and record all information on PNOMIS for a newly received prisoner relating to risk factors concerning previous acts of self-harm and suicide attempts and pass the information onto the appropriate staff. An ACCT will be opened if the prisoner is identified as posing a current risk of self harm.	Completed Head of Operations	

	risk factors of a newly-arrived prisoner when determining risk of suicide or self-harm including information from prisoner escort records and previous prison records; • that ACCT checks are made as directed, at unpredictable intervals and documented on the ongoing record; • that multidisciplinary case reviews are held with a consistent case manager and include all relevant people involved in a prisoner's care; • that a member of the healthcare team always attends the first ACCT review • that all risk factors, including recent suicide attempts, self-harm and bullying are fully taken into account when assessing risk; and • that issues identified in post-closure ACCT reviews are properly resolved and that further post-closure reviews are held when necessary.		All relevant information relating to a prisoner being at risk of suicide or self harm will also be recorded in the induction/first night process documentation. An Information to Staff notice was issued in September 2013 which provides information about observing a prisoner who is being managed under ACCT. Compliance with the instructions will be monitored by regular management checks. Multi-disciplinary case reviews will be held at the appropriate times to ensure the attendance of a consistent case manager and relevant personnel. Where a staff member cannot attend then a written report will need to be provided. Prior to the commencement of the first ACCT review, the Case Manager will liaise with the Healthcare Department to ensure that a member of the Healthcare Team attends the review. Staff will familiarise themselves with all the available information when assessing a prisoner's risk of self-harm and / or evidence of bullying for these meetings. Decisions will be recorded referencing the evidence available. The Case Manager will ensure that all the issues identified in post closure ACCT reviews are properly resolved by interviewing the prisoner and ensuring that any outstanding actions have been completed by the designated member(s) of staff. A new Notice of Staff about the importance of holding multi-disciplinary case reviews will be re-issued in December 2014.	Target date for completion: 31 December 2014 Head of Safer Custody Head of Healthcare	

6	The Governor and Head of Healthcare should ensure that the prisoners identified as being at risk of suicide and self-harm are referred urgently for a mental health assessment	Accepted	Following any incident that requires more than first aid intervention, is an act of self-harm or a ligature attempt, a Threshold Assessment Grid (TAG) referral is now completed and submitted to the healthcare team for review, and if clinically indicated a Primary Mental Health Assessment. A notice to staff was published in May 2014 outlining this process with information on how to access and complete the TAG. All applicable notes on SystmOne are screened by the mental health lead following significant self-harm and if a TAG has not been received then this will be followed up to ensure that the prisoner is reviewed by the nursing team. A Standard Operating Procedure was also drawn up in May 2014 and communicated to all staff through a Notice to Staff, outlining this process.	Completed Head of Healthcare	
7	The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Swinfen Hall has a Medical Emergency Response Code protocol which reflects the PSI and ensures that there are no delays in calling ambulances	Accepted	Guidance and instructions contained in the Local Security Strategy will be reviewed and updated to incorporate the Medical Emergency Response protocol detailed in PSI 03/2013 in January 2015. The Protocol will be communicated through information to staff notices (NTS), staff team meetings and training sessions in January 2015.	Head of Operations Target date for completion January 2015	