



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man in November 2014
at HMP Nottingham**

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 Nottingham on 14 November 2014. He was 65 years old. I offer my condolences to the man's family and friends.

An investigator was appointed. A clinical reviewer reviewed the man's clinical care in prison.

On 11 September, the day before the man was due to appear in court charged with 19 sexual offences against family members, he took an overdose and was detained under the Mental Health Act 1983. He was discharged from hospital five days later and, on 17 September, was remanded to prison. It was his first time in prison.

Despite a suicide and self-harm warning form from the court, the man's recent overdose and stay in a psychiatric hospital, prison staff did not assess him as at risk of suicide or self-harm. No one requested the medical records from his time in hospital. The man was referred for a non-urgent mental health assessment, which was delayed until the end of October, when he refused to engage.

Due to the nature of his charges, the man lived in the prison's vulnerable prisoner unit. There is little evidence of meaningful staff interaction with the man while he was on the wing. After his death, some prisoners alleged that other prisoners on his wing had bullied the man the night before he died. While we have not been able to substantiate these allegations, I am pleased the prison has taken action to improve safety on the unit.

Overall, reception procedures at Nottingham were poor and did not identify the man's risk when he arrived at the prison. I am also concerned that not all of the man's relevant health records were requested and followed-up, especially those related to a recent urgent hospital admission following an apparent suicide attempt. Finally, I am concerned that the man's mental health needs were not properly established or urgently assessed.

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

August 2015

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SUMMARY

1. On 11 September 2014, the man was admitted to the Queen's Medical Centre, Nottingham after taking an overdose of sleeping tablets and antidepressants. Because of the risk to himself, he was detained under the Mental Health Act and transferred to Highbury Hospital. He had been due to appear in court on 12 September, charged with 19 sexual offences against family members, so the hearing was postponed. The man was discharged from hospital on 16 September, and, on 17 September, he was remanded to HMP Nottingham. It was his first time in prison.
2. Court staff completed a suicide and self-harm warning form, and passed it to the prison, with details of the man's overdose, which were also on his escort records. There was a note on the warrant about his suicide attempt and recent discharge from hospital, indicating that the man needed to see a doctor. Despite this information, reception staff did not consider the man was at risk of suicide or self-harm, and did not refer him for a mental health assessment.
3. On 18 September, a doctor reviewed the man's medical records and referred him for a mental health assessment because of his recent overdose and hospital detention. He did not consider that the man needed to be monitored under ACCT procedures. No one took the man for his scheduled mental health assessment on 25 September, and, when the mental health nurse went to the wing to see him, officers said that they were too busy to open his cell. The mental health nurse rearranged the assessment for 28 October, over a month later. The man did not attend and, when the mental health nurse finally spoke to him on 31 October, he refused to be assessed.
4. There is no record that the man had an induction, any meaningful conversations with officers, or any contact with his personal officer in the two months he was at Nottingham. He lived in the vulnerable prisoner unit, because he might have been targeted by other prisoners as a result of the charges he was facing. After his death, some prisoners alleged that other prisoners had shouted at him the day before he died, because of the nature of his charges. They said that the man was upset about this.
5. We are concerned that reception staff appear to have relied too heavily on the man's presentation when assessing his risk of suicide or self-harm, rather than taking into account warnings from the court, his recent overdose, the nature of his charges and his recent psychiatric treatment. There is no record that healthcare staff tried to obtain records about the man's time in hospital and he did not have an urgent psychiatric assessment when he arrived. No one spoke to the man about how he was settling in, and he received no induction. We make four recommendations.

THE INVESTIGATION PROCESS

6. The investigator issued notices to staff and prisoners at HMP Nottingham informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
7. The investigator visited Nottingham on 19 November and obtained copies of relevant extracts from the man's prison and medical records. The investigator subsequently interviewed 15 staff and three prisoners.
8. NHS England commissioned a clinical reviewer to review the man's clinical care at HMP Nottingham. The clinical reviewer joined the investigator for interviews.
9. We informed HM Coroner for Nottingham of the investigation who sent the results of the post-mortem examination. We have given the coroner a copy of this report.
10. One of the Ombudsman's family liaison officers contacted the man's wife, to explain the investigation and to ask her if she had any matters she wanted the investigation to consider. She asked how it had been possible for her husband to take his own life in prison when he had previously attempted suicide in the community. The man's wife received a copy of the draft report. She commented that she did not receive help with funeral costs. This has since been resolved during the consultation period. The prison received a copy of the draft report and has submitted an action plan detailing how they will address the issues we raised. It is included at the end of the report.

HMP NOTTINGHAM

11. HMP Nottingham is a local prison serving the courts in Nottinghamshire and Derbyshire and holds over 1,000 men. Nottinghamshire Healthcare Trust provides health services at the prison.

Her Majesty's Inspectorate of Prisons

12. HM Inspectorate of Prisons last inspected Nottingham in September 2014. Inspectors reported that the prison was failing in most of its core responsibilities and that the prison was not safe enough, although G Wing, where the man lived, was described as reasonably safe and stable. Suicide and self-harm prevention procedures were not sufficiently good. Inspectors were not assured that arrangements to identify the needs or risks of new arrivals were thorough or properly communicated. Inspectors noted that the personal officer scheme did not function properly and staff were often unaware of the personal circumstances of the prisoners they were supervising.
13. Inspectors found that levels of violence at the prison were high and almost 40 percent of prisoners reported victimisation by other prisoners. The mental health team had a reasonable skills mix, and waiting times for secondary mental health assessments were very short, while waiting time for primary mental health assessments were reasonable. Inspectors judged the overall quality of healthcare as reasonably good.

Independent Monitoring Board

14. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its most recent published report for the year to May 2014, the IMB repeated previous concerns about the lack of healthcare staff involvement in prisoner induction programmes. The Board welcomed moves to limit G Wing prisoners to those who were vulnerable because of their offence, rather than including other prisoners with debt or other social problems in prison.

Previous deaths

15. The man's death was the second apparently self-inflicted death at Nottingham since 2013. We have previously recommended that staff should place less emphasis on a prisoner's presentation when determining their level of risk of suicide and self-harm.

Assessment, care in custody and teamwork (ACCT)

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

purpose of the ACCT process is to try to determine the level of risk, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

KEY EVENTS

17. The man was charged with 19 serious sexual offences against family members allegedly committed some years previously. He appeared in court on 9 May 2014 and was released on bail to re-appear on 12 September. On 11 September, Nottinghamshire Social Services contacted the police to say that the man had taken an overdose and said he wanted to die. The man was detained in a mental health ward at Queen's Medical Centre for observation under Section 2 of the Mental Health Act 1983.
18. The court postponed his hearing for five days, until 17 September, and the man was moved to a mental health unit at Highbury Hospital, Nottingham. The hospital discharged him on 16 September. On 17 September, the man appeared at court and was remanded to HMP Nottingham. There was a note on the man's court warrant that he should see a doctor, that he had attempted suicide and had just been released from hospital.
19. The man told a court custody officer that he had taken an overdose the previous week, but had no current thoughts of suicide or self-harm. The court custody officer noted the conversation on the Person Escort Record (PER), a document that accompanies all prisoners when they move between police stations, courts and prisons. He flagged that the man was at risk of suicide and self-harm due to his overdose, and he was at risk of physical or verbal abuse, because of the charges he was facing. The court custody officer also completed a suicide and self-harm warning form, indicating that the man had told him that he had taken an overdose the previous week.
20. In reception at Nottingham, an officer signed the man's escort record, which he received with his warrant. He said that he did not read the page on the escort record mentioning the man's risk of suicide and self-harm (the first page after the cover). When interviewed, the reception officer said he signed the escort record only to say that he had received the man's belongings from the court escort staff. He considered that the risk assessment elements of the form were for the information of the escort staff. The reception officer said he did not see the suicide and self-harm warning form at this point.
21. The reception officer passed the Person Escort Record (which would have had the suicide and self-harm warning form attached to it) and the warrant to acting Supervising Officer (SO) in charge of the reception area that day. She told the investigator she read the man's suicide and self-harm warning form but did not read all of the escort record. The man told her he had no thoughts of suicide or self-harm. The reception officer recalled that, when the SO referred to the information on the suicide and self-harm warning form, the man said that he had harmed himself because he thought that might mean he would not be sent to prison. The man said it was his first time in prison. The SO told the investigator she could not recall whether she had asked the man about his time in hospital.

22. The SO said that she did not consider the man at risk of suicide or self-harm, but knew that other staff would assess his risk during his reception and first night in prison. The SO wrote in the comments box of a cell sharing risk assessment that the man said he had no thoughts of suicide or self-harm, it was his first time in prison, he had arrived with a suicide and self-harm warning form and his warrant stated he needed to see a doctor as soon as possible. She did not write this information in the man's case history.
23. The reception officer completed a first night assessment. The man said he was feeling okay and the reception officer circled the word 'no' to standard questions about thoughts of suicide or history of self-harm. The reception officer concluded that the man was not at risk of suicide or self-harm, based on what he told him. He told the investigator that the man came across as arrogant.
24. During an initial health screen, the nurse noted that the man had hypertension and he was very tense and quite angry. She noted that he had been in hospital after taking an overdose, but he refused to be referred to the mental health team. The man told the nurse that he had taken 200 sleeping tablets and antidepressants. The nurse remembered that he made good eye contact during the health screen and did not seem suicidal. He told her that he did not want to be monitored. Despite the man's recent overdose, detention under the Mental Health Act and the nature of his charges, the nurse did not open an ACCT. She did not sign the suicide and self-harm warning form and did not recall seeing it. She requested the man's GP records, but did not ask for the records from his recent hospital stay.
25. After seeing the nurse, the man was taken to G Wing, the vulnerable prisoner unit, where he remained for the rest of his stay at Nottingham. Normally, new prisoners spend their first night in the prison on C Wing, the prison's first night centre and induction unit. However, vulnerable prisoners often go directly to G Wing, if places are available. Induction staff from C Wing are expected to provide an induction programme to new prisoners on G Wing, when this happens, but there is no evidence that the man ever received an induction.
26. On 18 September, a doctor reviewed the man's clinical record and referred him to the mental health team. He wrote in the clinical record that the man could not refuse to be referred as he had recently taken an overdose and had been sectioned (detained under the Mental Health Act.) A pharmacy technician, contacted the man's community GP surgery to clarify what medication he had been prescribed. She established that he had been taking medication for hypertension, depression, a gastro-intestinal complaint and painkillers. Dr Lloyd prescribed amlodipine, for hypertension, and lansoprazole for the gastric condition. The doctor did not prescribe antidepressants.

27. On 22 September, the man had an appointment with a doctor. He told the doctor he only wanted his blood pressure measured and his stomach medication prescribed. The doctor noted that the man did not want to talk about anything else and they did not discuss his previous prescription for depression,
28. On 25 September, the man did not turn up for an appointment with a nurse of the mental health team. The nurse went to G Wing to find out why, but he could not see the man as the two officers said they were too busy to unlock his door. The nurse rescheduled the appointment for 28 October.
29. From his arrival at Nottingham on 17 September, until his death on 14 November, the only entries in the man's case history notes are comments about public and child protection issues relating to his alleged offences. There is no evidence that any officer had any meaningful conversation with the man. The man had a personal officer, but made no entries in his case history at all. He told the investigator that he knew the man by sight from working on G Wing, and described him as a quiet man. The personal officer said that officers do not have time to carry out personal officer duties.
30. The man attended court on 26 September for a pre-trial hearing. Nothing was written on the front of his escort record to indicate his previous self-harm. He had two more pre-trial hearings; on 20 October and 27 October. The reception officer said he saw the man in reception, going to or returning from court and still found him arrogant. The reception officer said that the man had told him that he had done nothing wrong and would not be found guilty.
31. On 28 October, the man had a triage appointment in the mental health clinic but did not attend. The nurse from the mental health team went to see the man on G Wing on 31 October. The man told the nurse he did not need the services of the mental health team and the nurse discharged him from the service.
32. The man shared a cell with another prisoner throughout his time on G Wing. The man's cellmate told the investigator that he and the man got on well and shared the same small circle of friends on the wing. He described the man as a person who would stand his ground and had seen no evidence that he was being bullied. The man had told him he was in the process of changing his will, as he wanted a member of his family removed from it.
33. Another prisoner on G Wing, told the investigator that he got on well with the man, but the man did not mix with many people. The man had told him his court case was upsetting him, but did not go into details. He had said that if he got a long sentence, he would not serve it. The man's friend recalled him saying that he might get a sentence of 26 years and that there was no way he would serve that long. He said he was missing his grandson.

34. After the man's death, four prisoners wrote statements alleging that one prisoner on the wing had repeatedly called him a 'paedo' the day before he died. All four prisoners complained that they felt unsafe on the wing. They alleged that prisoners who were not there because of sexual offences were bullying those who were. One of the prisoners wrote that the man had been very upset, but that he might have been too scared to tell officers because of what might happen to him or his cellmate.

14 November

35. At 8.50am, the man's cellmate left their shared cell to go to work and the man stayed in the cell alone. CCTV showed that the man did not leave the cell anytime after 9.00am, and no one went to the cell. At 11.15am, the man's cellmate returned from work. He looked through the door observation panel, but could not see the man and the door was locked. Two prisoners in the cell opposite said they had not seen the man. The man's cellmate went back to his cell at 11.18am to check if the man had been using the toilet earlier. He said he could see part of the man's face along the wall and noticed a knot of green fabric outside the cell door. He called the man's friend, who looked through the panel and ran to alert staff.
36. A healthcare assistant was in the treatments room on G Wing at approximately 11.20am, when the man's friend ran up to her and said that a prisoner had hanged himself. She grabbed an emergency bag and ran to the cell, along with a nurse who had also been in the treatments room. At 11.22am, the healthcare assistant radioed a code blue (an emergency medical code used in circumstances such as when a prisoner is not breathing). The control room called an ambulance at 11.23am.
37. A prisoner told an officer and the personal officer that someone had tried to hang himself. The officers ran to the man's cell, and tried to unlock the door. There was a courtesy lock on the inside, and they could not unlock it. (Some cells have locks to allow prisoners to protect their belongings and give some privacy, but officers' key should override this.) An SO who was on an adjoining wing, ran to the man's cell and noticed the sheet tied over the top corner of the door. As the officer got to the cell, the SO released the courtesy lock and together they kicked the door open. The man fell to the ground.
38. The officer and SO pushed the door open, went into the cell and cut the bed sheet from around the man's neck. He was not breathing and did not have a pulse. The SO started chest compressions and the officer left the cell to allow two nurses to help with resuscitation. The nurses attached a defibrillator, but it advised no shock should be given.
39. Paramedics got to the cell at 11.35am, but they were unable to resuscitate the man and pronounced him dead at 11.59am.

40. A prison manager debriefed staff involved in the emergency response at 2.00pm. Those who attended told the investigator that they found it useful, and felt well supported by the prison. The prison reviewed all prisoners subject to ACCT monitoring, and reminded them of support available in the prison.

Family Liaison

41. A prison manager, and a family liaison officer, went to the man's home at 2.55pm that afternoon and informed his wife what had happened. The Governor wrote to the man's wife 11 days later, to express his condolences. It was three weeks before the family liaison officer contacted the man's wife again, by which time his funeral had taken place. The man's wife was given some clothing that she was told was her husband's, but this was not the case. The family liaison officer restored the man's property to his wife but the man's wife thought Nottingham had treated the handling of his belongings insensitively.
42. The prison eventually offered to contribute towards the cost of the funeral in line with national policy but the matter was not resolved until July 2015.

Post-mortem report

43. A post-mortem examination found that the man died from hanging. A toxicology report showed that there was no alcohol or commonly used drugs in his system when he died.

ISSUES

Assessing risk of suicide and self-harm

44. On 17 September, a court custody officer recorded on the man's suicide and self-harm warning form that he had taken an overdose the previous week. His suicide attempt was mentioned on his warrant, and in the Person Escort Record, yet no one concluded from this information that the man was at risk of suicide and self-harm. The reception officer said that he thought the PER was for escort staff's information, rather than to alert the prison to his risk. He said he did not see the suicide and self-harm warning form. The reception officer thought the man was arrogant, and despite his risk factors including the nature of the charges against him, his recent suicide attempt and the fact that it was his first time in prison, did not consider him at risk of suicide or self-harm.
45. We are concerned that the SO did not appropriately assess the man's risk when he arrived. She must have seen the warrant that mentioned the man had just been discharged from hospital after taking an overdose, but did not remember asking him about it. The SO signed the suicide and self-harm warning form to confirm its receipt, but said that she did not consider the man at risk, so did not open an ACCT. She seemed to rely on the fact that other staff would be assessing him. She did not record his risk factors in the man's case history.
46. The nurse conducting the initial health screen did not remember seeing the suicide and self-harm warning form, but asked the man about his time in hospital the previous week. He said that he did not want the mental health team to assess him. She said that she did not refer him, because she thought he might be more open to a mental health assessment once he had settled at the prison. The man told the nurse that he did not want to be subject to suicide prevention monitoring. The nurse said that he made good eye contact with her and did not seem depressed, so she did not start ACCT suicide and self-harm prevention procedures. She did not refer to his other risk factors.
47. Prison Service Instruction (PSI) 74/2011, about early days in custody, (which was the relevant instruction at the time) sets out mandatory reception procedures and says 'The PER and any other available documentation including Suicide & Self Harm Warning Forms, ACCT documents and CSRA assessments, must be examined, and the prisoner interviewed in Reception, to assess the risk of self-harm or harm to others by the prisoner, or harm from others.' As reception staff did not properly consider the information on the escort record and suicide and self-harm warning form highlighting the man's risks, we do not think that the prison complied with this instruction.
48. PSI 64/2011 (Safer Custody) lists a number of risk factors and potential triggers for suicide and self-harm. The man had a number of these risks. This was his first time in prison, he was in the early days of custody, had previously (and very

recently) self-harmed, he had had recent contact with psychiatric services, had recently been discharged from a psychiatric in-patient facility and had been charged with serious sexual offences against family members. PSI 74/2011 requires staff to interview new prisoners in reception to assess the risk of suicide and self-harm and expects all staff to be alert to the increased risk and to act appropriately to address any concerns. This includes opening an ACCT.

49. Despite his recent self-harm, his overdose the previous week, the charges he was facing and his recent detention in a psychiatric hospital, the reception officer, the SO and nurse all relied too heavily on his presentation and his assertion that he did not intend to harm himself. There is no evidence that they balanced this against his other known risk factors.
50. Staff judgment is fundamental to the ACCT system. It relies on staff to use their experience and skills, as well as local and national assessment tools, to determine risk. This must include the prisoner's known risk factors and their presentation. PSI 64/2011 states that 'all staff who have contact with prisoners must be aware of the triggers that may increase the risk of suicide, self-harm or violence and take appropriate action'. The need to take full account of risk factors on reception is a matter we have raised with the prison before. We make the following recommendation:

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

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

Mental health

51. The nurse did not refer the man for a mental health assessment because he did not want mental health support. She told the investigator that in retrospect, she should have referred him anyway. The doctor referred the man the next day, rightly asserting that the man should not be able to refuse a referral when he had so recently taken an overdose and been detained in a psychiatric hospital under the Mental Health Act. The mental health team's follow-up of this referral was

not sufficiently urgent, and the man refused to engage when the mental health nurse eventually saw him on 31 October.

52. No one requested the man's medical records from the Queen's Medical Centre or Highbury Hospital. In the absence of those records, we would have expected the man to be referred for an urgent psychiatric assessment. Just one week before he went to prison, the man's mental health needs were judged so acute that he was detained under Section 2 of the Mental Health Act 1983. Even before his hospital stay, he had been taking medication for depression from his GP, but that prescription was never discussed or continued at the prison. Having proper discharge information was an essential prerequisite for providing appropriate care for him at Nottingham. In the absence of that information, the prison should have made concerted efforts to make their own urgent assessment of his mental health needs.
53. Prison Service Order 3500 (continuity of healthcare) states that efforts should be made to retrieve any information required from the prisoner's GP or other relevant service he has recently been in contact with and emphasises the importance of continuity in the success of clinical interventions. Priority should have been given to ensuring that the information was received as soon as possible in case there was important detail about his ongoing care. Failing that, his mental health needs should have been urgently assessed. We make the following recommendation:

The Head of Healthcare should ensure that the mental health team assesses all new prisoners with identified mental health needs using all relevant information, including from community services, to ensure appropriate continuity of care and follow-up.

Bullying

54. Four prisoners on G Wing alleged that a prisoner shouted abuse at the man the day before he died. One prisoner said that the man was very upset by this, but had been too scared to talk to staff about it. All four prisoners described how prisoners who were not charged with or convicted of sexual offences on G Wing were intimidating those who were. In their statements, the prisoners named alleged perpetrators of bullying. There is no record that the man complained to staff or his family about other prisoners' treatment of him on the wing.
55. Since the man's death, prisoners who are not charged or convicted of sexual offences are no longer accommodated on G Wing. The safer custody office is now located on G wing and there is now one more officer working there. There is no additional evidence that the man was being bullied or threatened, other than the other prisoners' accounts, some of which related to their own experiences. However, we are satisfied that the prison has recognised this problem and taken action to address it.

The man's contact with staff

56. From his arrival at Nottingham on 17 September, until his death on 14 November, the only entries in the man's case history notes are about public and child protection issues relating to his charges. This was the man's first time in prison yet there is no evidence that officers had any meaningful interaction with the man or that he had had an induction programme.
57. The Head of Security and Operations told the investigator that there was no personal officer policy at the time of the man's death, yet according to the man's records, his allocated personal officer was the personal officer. In practice, it did not appear to be operating at the time. The personal officer made no entries in the man's case history notes, although he worked on G Wing. The personal officer said that he knew the man by sight, but said officers did not have time to put the personal officer scheme into practice. He had never introduced himself to the man.
58. Not only were there no personal officer entries in the man's case history notes, there were no entries from any other officers to indicate that they had checked on his wellbeing during his first weeks at the prison, which is a particularly risky time.
59. We are concerned at the apparent lack of staff interaction with the man. We make the following recommendation:

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

Family Liaison

60. The prison's family liaison officer did not contact the man's wife for three weeks after her initial visit on the day that the man died. She told the investigator that she was not given any time to carry out her family liaison officer duties, as well as her core duties. We are also concerned that it took the Governor 11 days to write to the man's wife to express his condolences. His wife said she thought that he was not bothered by her husband's death. Finally, the prison gave the man's wife property that did not belong to her husband.
61. The prison has a responsibility to liaise sensitively with a prisoner's family after a death. We consider that the prison did not adequately meet this responsibility and we make the following recommendation:

The Governor should ensure that family liaison work is appropriately resourced and conducted sensitively to provide meaningful support after a prisoner's death.

RECOMMENDATIONS

1. The Governor should ensure that there are effective operating procedures in reception and that all staff understand the procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular, staff should:
 - Have a clear understanding of their responsibilities and the need to record relevant information about risk;
 - Consider and record all the known risk factors of newly arrived prisoners when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms, PERs and medical records;
 - Open an ACCT whenever a prisoner has recently self-harmed, expressed suicidal intent or has other significant risk factors, irrespective of their stated intentions.
2. The Head of Healthcare should ensure that the mental health team assesses all new prisoners with identified mental health needs using all relevant information, including from community services, to ensure appropriate continuity of care and follow-up.
3. The Governor should ensure that officers have meaningful recorded contact with every prisoner, particularly in their early weeks at the prison. All prisoners should have a named officer who should be aware of their individual needs, who they can approach for help and who will make regular checks on their wellbeing, backed up by good quality entries in their case notes.
4. The Governor should ensure that family liaison work is appropriately resourced and conducted sensitively to provide meaningful support after a prisoner's death.

Action Plan					
No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	<p>The Governor should ensure that there are effective operating procedures in reception and that all staff understand the procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular, staff should:</p> <ul style="list-style-type: none"> • Have a clear understanding of their responsibilities and the need to record relevant information about risk; • Consider and record all the known risk factors of newly arrived prisoners when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms, PERs and medical records; • Open an ACCT whenever a prisoner has recently self- 	Accepted	<p>A reminder will be re-issued to staff as per PSI64/2011 as an instruction requiring them to record relevant information about risk, consider all the known risk factors when deciding on the likely risk of suicide and self harm (including prisoner escort records, , medical records and self-harm warning forms.)</p> <p>These instructions will also include the need to open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent or any other significant risk factors.</p> <p>Training for all staff will include these updates and will be delivered on a rolling basis.</p> <p>The safer custody will check compliance with this instructions on a quarterly basis.</p>	<p>Head of Safer custody</p> <p>1st July 2015 for the issue of staff reminder for PSI 64/2011 instructions.</p> <p>1st Feb 2016 for staff training</p>	

Action Plan					
No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
	harmed, expressed suicidal intent or has other significant risk factors, irrespective of their stated intentions.				
2	The Head of Healthcare should ensure that the mental health team assesses all new prisoners with identified mental health needs using all relevant information, including from community services, to ensure appropriate continuity of care and follow-up.	Accepted	A system will be put in place to ensure that all new receptions who have any identified mental health needs are referred for a mental health assessment. This will include reviewing all relevant information when the initial assessment of need is made, including from community services. Clear instructions will be issued to all nursing staff who conduct initial health screening to ensure they adhere to this policy. The Head of Healthcare will carry out management checks on a quarterly basis to check compliance with this instruction and appropriate continuity of care and follow up.	Head of Healthcare. 1 st July 2015.	
3	The Governor should ensure that officers have meaningful recorded contact with every prisoner, particularly in their early weeks at the prison. All prisoners should have a named officer	Accepted	As part of a local initiative, prisoners will have a personal named officer as a first point of contact. The names of these officers will be placed above the cell doors of prisoners. Contact with prisoners through this scheme will be recorded on CNOMIS	30 th August 2015 Head of Residence and	

Action Plan					
No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
	who should be aware of their individual needs, who they can approach for help and who will make regular checks on their wellbeing, backed up by good quality entries in their case notes.		case notes. Management checks will be completed by Wing Custodial Managers (CM's) These checks will be recorded on CNOMIS as being completed.	Services	
4	The Governor should ensure that family liaison work is appropriately resourced and conducted sensitively to provide meaningful support after a prisoner's death.		Systems will be put in place with the Detail in order that on any future deaths the family liaison officer (FLO) will be given adequate time in order to provide a good standard of service to the family – a mobile phone will be purchased to ensure that liaison with the family can be provided and FLOs not having to use their own phones.	30 th July 2015 Head of Safer custody	