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 Elmley 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 Elmley in March 2014. He was 40 years old. I offer my condolences to his family and friends.

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

The man had been released on licence from a 13 year prison sentence on 28 February, but was recalled shortly afterwards. The formal reason give was that he had failed to return to his probation hostel by the required time. (He was being questioned by the police at the time after his probation officer told them that his partner had alleged he had threatened her.) He arrived at Elmley on 10 March and told reception staff that he had no thoughts of suicide or self-harm. A nurse referred him to the mental health team because she noted he had a history of anxiety and depression. At first, he believed he had been recalled for a fixed period of 28 days, but then realised that he faced the prospect of serving a number of years in prison – possibly until his sentence expired in 2022. He did not accept the reasons for his recall, but never received the formal written notification. He spoke to his partner most days he was at Elmley but he said that she had ended their relationship on 21 March. Shortly afterwards a prisoner found him hanged in his cell.

I am concerned that, when he arrived at Elmley, the man had several factors which made him at increased risk of suicide and self-harm but it is not clear that prison staff fully considered them. He was very anxious about being recalled and asked for more information a number of times, but had still not received his recall papers when he died. The reasons given for his recall were inadequate. He spoke to several probation officers during his time at Elmley and was often upset, but they did not consider he was at risk of suicide and self-harm. Prison staff also missed opportunities to identify his risk and support him. He had been referred to the mental health team, who recommended counselling which he never began. A further referral to the mental health team with additional concerns was never actioned.

Required emergency procedures were not followed after the man was found hanging and it is unacceptable that, for the sixth time since 2012, I have to make a recommendation to Elmley about the need for staff to use the required emergency code and call an ambulance immediately in a life-threatening situation. The Governor needs to make sustained and active efforts to ensure that all prison staff follow mandatory Prison Service emergency procedures.

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 **March 2015**

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SUMMARY

1. The man was released on licence from HMP Highpoint on 28 February and was required to live at a probation approved premises. On Friday 7 March 2014, his partner told a probation officer that he had threatened to kill her and that she intended to report it to the police. When she had not done so by the end of the day, the probation officer told the police what she had said. The police arrested him and questioned him about the allegations (which his partner subsequently withdrew). This meant that he was not able to return to his approved premises by the required curfew time in line with his licence. When he was in police custody he said that he suffered from depression and anxiety but had no current thoughts of suicide or self-harm. The next day, his licence was revoked because he had not returned to the approved premises when he should have done and he was recalled to prison.

2. On Monday 10 March, the man was taken to HMP Elmley. No one identified him as at risk of suicide and self-harm when he arrived, although he had previously self-harmed in prison, suffered anxiety and depression and had been recalled to prison, factors which increase risk. A nurse in reception referred him to the mental health team because of his record of depression and anxiety.

3. On 12 March, a probation officer at Elmley spoke to the man, who was distressed and tearful. He disputed the reason for his recall. The probation officer agreed to contact his community probation officer in Ilford to find out more information. On 14 March, the prison probation officer told him that he had been recalled because his partner had alleged that he had threatened to slit her throat. He said that he could not cope with being in prison and was tearful and agitated. The officer did not begin Prison Service suicide and self-harm prevention procedures, known as ACCT, as he said that he had no thoughts of harming himself. He said that he wanted to see a mental health nurse and the probation officer referred him to the mental health team. The team did not take any action as they thought it was a duplicate referral (in addition to the one from the reception nurse) and not because of new concerns.

4. On Friday 21 March, the man spoke on the telephone to a senior probation officer at Ilford probation office, who explained the reasons for his recall and told him that he would not be released after 28 days as he had hoped. He was upset about this. He told the senior probation officer that his partner had ended their relationship. The senior probation officer did not make a note of this conversation and did not alert the prison about any concerns. He never received the formal notification of his recall (which he should have received within ten days) setting out the reasons, although it had arrived in the prison on 17 March, with a covering letter drawing attention to his risk. No one took any action as a result of the warning.

5. The officer who unlocked the man's cell at 9.15am on the day of the incident does not appear to have checked his welfare. At about 9.39am, another prisoner went to his cell and found him hanging with torn bed sheets around his neck attached to the bed frame. He called for help and officers responded but did not use the required emergency medical code and there was a five minute

delay before the control room called an ambulance. Prison officers and a nurse were unable to resuscitate him. A prison GP came to the cell and pronounced his death at 10.02am, shortly before paramedics arrived. The prison asked staff from another prison to break the news of his death to his partner. This did not gain any time advantage and meant that the staff were not able to answer his partner's questions as well as staff from Elmley would have been able to do.

6. We are concerned that no one identified that the man's evident distress about his recall and other risk factors increased his risk of suicide and self-harm. No one appears to have considered beginning ACCT suicide and self-harm procedures. Although staff referred him twice to the mental health team, he never had a mental health assessment. While it appears that there were sufficient concerns to justify his recall to prison, probation staff gave differing accounts of the reasons and he did not receive the recall documents with the formal reasons before he died. The reasons supplied were inadequate. We are concerned that the officer who unlocked his cell on the morning of his death did not check his wellbeing and the prisoners who found him were not well supported after his death. The required emergency radio code was not used and there was a delay in calling an ambulance – the sixth time we have raised this issue since 2012. We make nine recommendations.

THE INVESTIGATION PROCESS

7. We issued notices to staff and prisoners at HMP Elmley about the investigation. No one responded.

8. The investigator obtained the man's clinical and prison records. NHS England, Kent Area team, commissioned a clinical reviewer to review his clinical care in custody.

9. In May and June 2014, the investigator interviewed staff and prisoners at Elmley. On 23 July, he interviewed the man's probation officer at Ilford probation office. We were unable to interview one prison officer, who had left the Service and was not willing to be interviewed, and one prison officer and a senior probation officer who were unwell.

10. We notified HM Coroner for Mid Kent and Medway District of the investigation who provided a copy of the post-mortem report. We have sent the Coroner a copy of this report.

11. One of the Ombudsman's family liaison officers contacted the man's partner and his aunt about our investigation. His partner asked for a detailed chronology of what happened. She asked us to consider whether the prison had missed any signs that things were 'not right' for him and whether the prison should have acted differently to support him. She said that his barrister had told him that the recall would be for a 28 day period but he had been worried that he would have to spend the full eight years remaining of his sentence in prison. She was concerned that although he had died at around 10.00am, she had not been informed of his death until 3.30pm, and that this was by staff from another prison.

12. The man's aunt also asked for more details about the chronology of events. She believed her nephew should have been identified as at risk of suicide and self-harm and given additional support. He had been very distressed about the length of further time he might have to serve and had attempted to clarify this with the Probation Service who had failed to get back to him. She said that he had attempted suicide in HMP Pentonville seven years earlier, after his mother died, and this should have been taken into account. She asked the investigator to listen to telephone calls he had made two days before his death which showed he had been distressed.

13. The man's aunt received a copy of the draft report. The solicitor representing her wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

14. The man's partner received a copy of the draft report. She pointed out a factual inaccuracy and the report has been amended accordingly.

HMP ELMLEY

15. HMP Elmley is part of the Sheppey group of prisons, which includes HMP Standford Hill and HMP Swaleside. Elmley serves the courts in Kent and holds remanded and sentenced adult men, and unsentenced young adult men between 18 and 21. It can hold more than 1,200 prisoners in five wings, with a mixture of single, double and triple cells.

Her Majesty's Inspectorate of Prisons

16. The report of a recent inspection of Elmley has not yet been published but in preliminary feedback, the Inspectorate told us that Elmley had a rolling action plan incorporating all recommendations made in previous PPO investigations into deaths at the prison. Inspectors found that many of the actions merely resulted in the re-issue of guidance documents or notices to staff, rather than effective action to drive and check performance. At the previous inspection in March 2012, inspectors found that reception procedures were adequate and that new arrivals were well supported. Incidents of self-harm were lower than in many local prisons and prisoners in crisis received good levels of care, particularly from Listeners (prisoners trained by the Samaritans to support other prisoners). There was a wide range of interventions for prisoners with mental health problems.

Independent Monitoring Board

17. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its most recent annual report for the year to October 2013, the IMB was concerned about high levels of staff sickness and its impact on the operation of the prison. The IMB noted that there had been an increase in the number of ACCT documents opened, although the level of serious self-harm had gone down. The IMB considered that staff awareness of self-harm issues had improved.

Previous deaths at HMP Elmley

18. Between 1 January 2012 and 22 March 2014, when the man died, there had been seven deaths at Elmley. Four of these were apparently self-inflicted, two from natural causes and one a medication overdose. We made recommendations about calling ambulances in emergencies in five of these cases. In two of the cases we were concerned that there were delays in contacting families after the prisoner died. These issues were again identified as concerns in this investigation.

Recall to Prison

19. When prisoners are released 'on licence', they are required to adhere to certain conditions while serving the remainder of their sentence in the community. Released prisoners on licence are supervised by an offender manager, also known as a probation officer. When released they will be given a copy of their

licence with all the conditions they need to adhere to such as requirement to behave appropriately and not commit further offences or undertake any activity that might undermine their resettlement in the community. They will be expected to maintain contact with their supervising probation officer and live at an address approved by their probation officer. Conditions can include a curfew requirement.

20. Offenders on licensed supervision in the community are liable to recall to prison if they fail to comply with their licence conditions. All supervision licences contain standard conditions, which are designed to enable the Probation Service to manage the risk that offenders may pose on release from prison and to safeguard public protection. The request for a recall from the Probation Service is considered by the NOMS Public Protection Casework Section (PPCS) on behalf of the Secretary of State for Justice. PPCS will consider the legitimacy of the recall taking account of the offender's reported behaviour, original offences and nature of risk.

21. If the offender is not assessed as representing a risk of harm to the public, he/she will be recalled on a fixed term recall basis. Offenders recalled on a fixed term basis are automatically re-released from custody 28 days after their return to custody. Offenders who are not assessed suitable for a fixed term recall are recalled on a standard basis and are liable to be detained in prison up until the expiry of their sentence.

22. All recalled offenders must have their case reviewed by the independent Parole Board if they are detained in prison for a period longer than 28 days. The Parole Board's powers on review are to direct immediate release on licence, to fix a date for the offender's release on licence within one year of the review or to make no direction for release. An offender's case must be referred back to the Parole Board within a year of their previous determination of the case if the offender is not released before that date. All offenders are provided with detailed reasons for their recall to prison and details of how they can make representations to the Parole Board as to their ongoing detention.

Assessment, Care in Custody and Teamwork (ACCT)

23. ACCT is the Prison Service process for supporting and procedures prisoners at risk of harming themselves. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this 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

Events leading to the man's recall

24. In May 2008, the man was arrested, charged with robbery, grievous bodily harm and possession of an offensive weapon and remanded to HMP Pentonville. In December 2008, he harmed himself and was managed under ACCT suicide and self-harm prevention procedures for two months. On 6 October 2008, he was sentenced to 18 months for robbery and, in January 2009, was sentenced to 13 years for grievous bodily harm, to be served consecutively. He served time in a number of prisons.

25. The man became eligible for parole and was released on licence from HMP Highpoint on 28 February 2014. His licence expiry date was 24 November 2022. That day, he and his partner saw his probation officer at the London Probation Trust office in Ilford. She explained his licence conditions to him, one of which was to reside at an approved premises (formerly known as probation hostel) in Ilford. She and a senior probation officer met him at the approved premises on 5 March. She told the investigator that he was anxious during most their meetings and did not want to live in the Ilford area as he did not want to mix with old associates.

26. Around lunchtime on 7 March 2014, a senior probation officer at the Ilford office recorded that she had received a phone call from the man's partner that morning who said that she had ended her relationship with him as she believed he was using class A drugs. She also recorded that his partner alleged that he had telephoned her that morning and threatened to slit her throat, and that she would be reporting this to the police. She asked her to let her know when she had done so. (On receipt of the draft report his partner said she did not at any time allege he had threatened to slit her throat. She told us that she had been concerned that he was taking drugs again and told the probation officer that if they did not do anything to help him and he did cut her throat her blood would be on their hands. She said she would go to the police if she felt in danger, which did not ensue.) She contacted the approved premises who told her that he had been tested for drugs that morning. (The result indicated that he had taken an illicit substance.) She did not hear back from the man's partner and, after being unable to contact her between 5.00pm and 6.00pm, made a third party report to the police about what she had alleged earlier that day. The man's partner said that they went voluntarily to the police station to demonstrate that he had not harmed her, but at 8.35pm, the police arrested him to question him about the earlier allegations. In her statement to the police she did not mention that he had threatened her. He remained in custody and was therefore unable to return to the approved premises by his curfew time of 11.00am.

27. While he was in police custody, the man told the police that he was taking pregabalin for pain for a leg injury sustained in 2008 and that he suffered from depression and anxiety but did not take any medication for this. He said that he had never self-harmed. The police custody officer did not record any concerns about his mental health or risk of suicide or self-harm.

28. At 12.10am on Saturday 8 March, the Ministry of Justice revoked the man's licence because he had been absent from the approved premises after the curfew time of 11.00pm on the night of 7 March. At 2.47am, a police doctor examined him and recorded that he looked well but was anxious. He prescribed diazepam to alleviate anxiety, which staff gave to him at 2.52am (2x5mg), 12.31am (3x5mg) and 8.15am (2x5mg) on 9 March. The police brought no charges against him.

The man's arrival at HMP Elmley

29. On 10 March, the man arrived at Elmley. The Person Escort Record (PER) that accompanied him recorded that he was a licence recall prisoner, had a sore leg and suffered from depression and anxiety.

30. A Supervising Officer (SO) recorded that the man was a licence recall prisoner and that his next of kin was his partner. He then went to the prison's first night centre on houseblock 1, where, shortly after 7.00pm, an officer recorded that he was a licence recall prisoner, had no thoughts of suicide or self-harm and that he had signed the prison communications compact. She noted that he did not have any concerns. She gave him a PIN number to operate the prison telephone system and he submitted an application to add some telephone numbers. She assessed that he was suitable to share a cell. She told the investigator that she did not remember him.

31. At 7.21pm, a mental health nurse saw the man for a reception health screen and recorded his weight, height and blood pressure. He told her that he smoked around 20 cigarettes a day and did not abuse alcohol or drugs. She told the investigator that she had reviewed his medical record before she saw him and was aware of his history of drug misuse and that he had been prescribed medication for a leg injury.

32. The nurse noted that the man was calm and coherent, maintained good eye contact throughout and had no psychotic symptoms. He said that he had no previous or current thoughts of suicide or self-harm. He thought that he was subject to a 28 day licence recall and would be able to cope in prison. She told the investigator that she had no concerns about him and reminded him of the support available if he found it difficult to cope. She referred him to the mental health team because of his history of anxiety and depression and to the prison GP, for the medication he needed for his leg pain. She noted that he was fit for a standard prison location, and could work and attend the gym. She had no concerns about him sharing a cell.

33. A prison doctor then examined the man. He told the investigator that the man was relaxed and just wanted pregabalin for his leg pain. The doctor recorded that he was a licence recall prisoner and had been referred to the mental health team because of his history of anxiety and depression. The man told him that he had no thoughts of self-harm or suicide. The doctor prescribed pregabalin.

34. Just after 8.00pm, the man phoned his partner. The records of the call show that they spoke about his recall to prison and she said that he had been recalled because he had not returned to the approved premises by the curfew. She believed that he would only have to spend 28 days in prison. He said he did not accept the reasons for his recall. His partner said that he had repeatedly lied to her, that he was having a relationship with another woman and was taking drugs. She said she had been angry about how he had treated her and had informed probation staff before he was recalled that their relationship was over and that it would be their fault if he killed her. He pleaded with her to get him released from prison. He asked for his solicitor's and a friend's telephone numbers.

35. At 12.46pm on 11 March, a mental health nurse noted in the man's medical record that the in-reach team had reviewed his medical record at a referral meeting. The team referred him to a counselling service at Elmley as the most suitable treatment for his depression and anxiety. At 3.04pm, a nurse examined him for a secondary health screen and identified no additional issues.

Wednesday 12 March 2014

36. At 11.05am on 12 March, the man saw a probation officer based in the prison. He said that the man was distressed, tearful and agitated. He said that he had only been out of prison for a week before being recalled and he did not want to be back. He disputed the reason for his recall and said that he had been unable to comply with the approved premises curfew because he had been in police custody at the time. His partner had withdrawn an allegation that he had threatened her. He said he had to calm him down before he could talk to him and told him that he would investigate the reason for the recall. However, his community probation officer was unavailable and he could not obtain the recall report on the computer system. He told the man that he would speak to him again when he got further information. He said that he was calm at the end of their meeting and he had not considered that he was at risk of suicide and self-harm.

37. Later that day the man moved to houseblock 5. That afternoon another prison probation officer reviewed the man's OASys report (an assessment of risk and needs) to see if his reason for return to prison highlighted any potential risk factors. His OASys report, which had last been updated in January 2014, indicated some concerns about domestic violence and about his potential for self-harm. She completed a custodial risk form and emailed the safer custody unit and the houseblock to alert the staff to his potential risk. She copied the e-mail to the previous prison probation officer. The email said:

> *Please be advised of the following concerns in relation to suicide/ self harm risk, from oasys dated 03/01/14: S10 "Pre-release OASys*
>
> *There has been concerns regarding depression and anxiety. He has been noted to say he is not doing a life sentence, he will either leave or shoot himself into a box". He is now engaging with the In-reach Mental Health Team. He has also been fearful of other associates and reprisal. The team*

to complete a referral for seamless transition of his care once in the community.

38. The probation officer added the email to the man's prison record at 2.16pm and asked that this information should be recorded in the wing observation book. The investigator found no information about him in the observation book for this date.

39. At 3.26pm, the man phoned his partner and told her that he did not want to be in prison and did not know how long he would be there. He said he was worried about their relationship and was scared that she would leave him. She said that she would not promise anything and was disappointed that he had taken drugs. She said that she had telephoned Ilford Probation Service about his general behaviour and told him to contact his solicitor.

Thursday 13 March 2014

40. On 13 March, the man phoned his partner at 8.19am. They argued about his relationship with another woman and his partner said that she had told the police the truth. (It is not clear what she meant by this, but it is possible that she meant that she had told the police that he had not threatened her.) He pleaded with her not to end their relationship. The conversation ended when he ran out of telephone credit. Later that day, he submitted an application saying that he should not have been recalled to prison and wanted this resolved.

Friday 14 March 2014

41. On 14 March, an officer from the prison's offender management unit telephoned the Ministry of Justice recall team who told him that the man's licence had been revoked under standard recall terms and they would issue his recall pack soon. This meant that he was not in prison for a fixed 28 day recall.

42. The prison probation officer spoke to the senior probation officer about the man's recall. She said that his partner had told her that he had threatened to slit her throat with a knife, but she had later withdrawn the allegation. However, probation staff were concerned that his behaviour had become chaotic in the community. As his index offence involved using a knife, they had decided to recall him to prison.

43. At around 3.00pm, the probation officer saw the man. He said that he found it difficult to concentrate and understand what said he told him about the circumstances of his recall. He was tearful and agitated and said that he could not cope in prison and should not have been recalled. He said he was not suicidal but he wanted to see a mental health nurse. The probation officer said that their conversation lasted at least 30 minutes by which time he appeared to have calmed down.

44. At 3.45pm, the probation officer sent a referral form to the mental health in-reach team. He noted that the man was distressed, emotional and finding it

difficult to cope with being back in prison. He added that his probation officer and the senior probation officer from Ilford probation team thought that he might have a personality disorder. The prison probation officer included the extract from the man's OASys report of January 2014 which noted his history of depression, anxiety and his risk of suicide and self-harm. He told the investigator that he had been ACCT trained and did not think that the man was at risk of suicide or self-harm. He recorded what had happened at their meeting in the houseblock observation book. He said he received a phone call shortly afterwards from the in-reach team confirming that they had received his referral and had also received one a few days earlier.

45. On 14 March, an officer from the public protection casework section sent a notice to Elmley setting out that the man was subject to standard recall. In her letter she highlighted information that he might be vulnerable in custody and that he was emotionally unstable, at risk of self-harm and vulnerable to bullying. The letter noted that he had traits of personality disorder which required diagnosis. There is no evidence that anyone read the letter or took any action as a result of the information in it.

Monday 17 March 2014

46. The man made three prison applications on 17 March. He asked for permission to access his mobile phone in reception to retrieve some numbers to add to his phone account and to get some property. In the third application, he said he had spoken to his solicitor about his recall and now wanted to see the prison probation officer. (Calls to solicitors are legally privileged and not recorded so we have been unable to review any of those calls.)

47. At 10.22am, a mental health nurse recorded in the man's medical record that he was still waiting for the counselling service to assess him but was no longer under the care of the mental health team.

48. The man phoned his partner at 11.03am. He told her that he had not slept and could not get though prison without her. He begged her not to end their relationship. At 11.11am, he phoned his probation officer and told her that his partner had made a false allegation against him which she had now withdrawn. He begged her to get him out of prison. He said he was not sure about how long his recall was for and that he could not spend any more time in prison. She tried to reassure him that this would be looked into. She said that she had not received any information from the police about what had happened about his partner's allegation and that the information about his recall was being collated as quickly as possible. She advised him to speak to his prison probation officer about this.

49. At 11.47am, the man phoned a friend and discussed his recall. He admitted that he had made a mistake by having a relationship with another woman. He said that on 14 March, the prison probation officer had told him that he was not subject to a 28 day fixed recall period because of the seriousness of his original offence. He phoned his solicitor at 12.00pm. A few minutes later, he called his friend again and said that someone at his solicitor's office had said that they no

longer dealt with legal aid cases such as his. His friend gave him his solicitor's mobile number and said he should phone him directly. He said he would have this number added to his telephone account.

50. After lunch, at 1.55pm, the man phoned his partner. They talked about their relationship and he said he would tell her the truth. He admitted that he had taken subutex (an opiate substitute) and had drunk lager. He apologised to her for his mistakes and said he was nothing without her. His partner told him to ring his solicitor. He said his phone credit was running out.

51. That day, a prisoner moved into the man's cell. The public protection casework section sent his recall pack to Elmley that day.

Tuesday 18 March 2014

52. At 8.32am on18 March, the man telephoned his partner and apologised for not calling her the previous night but said he had now been given £2 emergency phone credit and some tobacco. He gave his partner the phone number of the prison so that she could book a visit. Just before his phone credit expired, she partner told him to ring his solicitor.

53. That day the prison probation officer signed and dated a pro-forma indicating that the recall pack had been disclosed to the man (although it had not been). He told the investigator that it was not standard practice to review the whole recall pack. He did not see or speak to him, but he had sent the recall pack to houseblock 5 for officers to give to him. He did not check with the officers that they had given the recall pack to him.

54. A mental health nurse recorded in the man's medical record that day that he had been discharged from the mental health team. She told the investigator that he was discharged from the mental health in-reach team's case load and placed on the primary mental health care list. Although his medical record suggested there was a second referral (which we presume was from the prison probation officer on 14 March), she told the investigator that she was not aware of this referral and could not find a reason for this second record. She said SystmOne (the electronic medical record) was a complex system to use and staff sometimes experienced had difficulty using it.

55. The Head of the mental health in-reach team said that it was not unusual for similar referrals to be sent to the in-reach team by different people or agencies at the same time. She said that the prison probation officer's referral was the second one the team had received, in addition to the one from the reception nurse. As he had identified different risk factors in his referral, she considered that this should not have been treated as a duplicate referral and that the in-reach team should have seen the man.

Wednesday 19 March 2014

56. The man submitted three more applications forms on 19 March. He asked to see someone from the offender management unit to discuss his situation, and

he wanted the prison to send information to the community probation officer. He asked for some clothes to be returned to him. He also wanted to get some more telephone numbers from his mobile phone.

Thursday 20 March 2014

57. On 20 March, the man asked to transfer to HMP Wayland as it was nearer to his family and had better courses for prisoners. In a second application, he noted that he wanted to get his mobile phone from the prison reception area to give to his partner.

Friday 21 March 2014

58. On 21 March, the man made an application addressed to the prison probation officer. He said that he had been in prison for 12 days and had still not received his recall pack.

59. The man's cellmate told the investigator that the man was having relationship problems and he had helped him to write letters to his partner. He said that the man was "going crazy" because he did not know how long he would be in prison. After he came back from work at midday, wing staff told him that he would be moving to a different part of the houseblock, as he had asked to be with some other prisoners he knew.

60. The man made six telephone calls that afternoon. He called his friend at 2.05pm and told her that he had spoken to his solicitor's office, who said they would not be representing him. He was frustrated at their response. At 2.09pm, he spoke to his partner. He was upset and believed she would end their relationship. He said he had made mistakes but could not manage without her. They argued about a watch that she had given to him. At 2.13pm, he phoned his community probation officer, who was not in the office. He was advised to call back later to speak to the senior probation officer.

61. The man then went back to his cell, where his cellmate was packing. He told him that his partner had ended their relationship. The cellmate said the man was distraught and he felt guilty that he was moving when he was so upset and probably wanted someone to talk to. He moved cells shortly afterwards.

62. The man tried to speak to the senior probation officer at 2.59pm but she was not available. He called his partner again at 3.21pm and left a message in which he said he was sorry, he loved her and had sent her a letter.

63. The man spoke to the senior probation officer at 3.39pm. He told her that he was scared and did not want to be back in prison. He said that he had still not received his recall documents and believed that his partner had told the Probation Service that he was using drugs again. She told him that at the time of his recall she had been concerned about him as he had failed a mandatory drug test on 7 March at the approved premises and his partner had said he had threatened her. She said that the Probation Service had passed this information to the police who had arrested him. He became upset and told her

that he had complex needs and needed a lot of support. He said he thought he would never leave prison and that his relationship with his partner had ended. She told him that it would be for the Parole Board to decide how long he would serve in prison and confirmed that he was not subject to a 28 day fixed term recall. He said he had no one in prison and did not want to be there any longer. She said he should try and stay strong but he said he could not. She did not report his state of mind to anyone at the prison and there was no recorded evidence to suggest that she considered whether he was at risk of suicide and self-harm.

64. Around 4.00pm, the man asked a SO if he could call his family from the staff office and if he could add some money to his phone account outside the normal time period. The SO said that he would have to check if there were any restrictions about who he could contact and he would let him know when this was done. He told him later that he could not add any money to his telephone account that afternoon because the cashiering system was shut until Monday.

65. A prisoner told the investigator that the man's mood had been up and down, partly as he did not know how long he would be in prison. He said that the man had told him that evening that his partner had ended their relationship. He said that the man was devastated about this and about being back in prison. However, he said that he did not see any signs that he intended to harm himself.

66. An operational support grade (OSG) arrived for duty around 8.30pm. The officer on duty handed over to him and he then checked all the cells. He had no concerns about any of the prisoners at the time.

Day of the incident

67. The OSG recorded that he completed the morning roll check at around 5.30am. (There is no CCTV on the wing to verify these timings.) After the man's death, he wrote a statement to the Governor and said that when he had checked the man, he was lying on his back asleep. Officer A took over from the OSG at 7.30am. He told the investigator that he conducted a further check of each prisoner on the wing. At the time he said that all the prisoners, including the man, were either sleeping or watching television.

68. Officers unlocked prisoners at 9.15am that morning and Officer B unlocked the cells on the man's side of the landing. This officer has since left the Prison Service and declined to be interviewed for this investigation. We were therefore unable to ask him whether he had got a response from him when he unlocked his cell. Officer A unlocked the cells on the opposite side of the landing. It was the day when prisoners collected their weekly prison shop orders and they formed a queue on the ground floor outside the office, where a SO was based.

69. Shortly before 9.40am, the man's ex-cellmate went to the man's cell, as he thought he might have left his prison ID card there. The cell door was closed, but unlocked, and he went in. It was dark inside as the window was covered

and the television was off. He said good morning and expected to see him in bed. However, he found him hanging from torn strips of bed sheet attached to the top bunk bed. He said that he looked lifeless. Another prisoner came to the cell seconds later and when he saw the man hanging he ran to alert wing staff.

70. Officer B responded to the prisoner shouting and ran to the man's cell, followed by Officer A and Officer C. Officer A told Officer C to press the landing general alarm button. (The prison incident log records this at 9.40am). Officer B radioed the prison control room stating "Urgent Message" and explained the nature of the incident and gave the location. He cut the ligature and Officer A helped him place the man on the floor. Both officers said that they could not find any signs of life. Officer B began cardiopulmonary resuscitation by administering chest compressions. Officer A, who was first aid trained, tilted the man's head back to ensure that his airway was clear to give rescue breaths.

71. Officer D responded to the general alarm and arrived at the cell within a minute. Officer C was outside the cell and told her what had happened. The officers were still continuing cardiopulmonary resuscitation. Officer D radioed to request the healthcare emergency responder to come immediately to houseblock 5. (This was recorded in the incident log as at 9.41am.) She shouted to the SO on the ground floor and told him that he was needed on the second landing.

72. The SO was taking prisoners back to their cells when Officer D called him. He said that when he got to the cell the man had a prominent ligature mark around his neck and looked yellow. He asked another SO to start a log of events. A custodial manager arrived and established that an ambulance had not been called. He contacted the control room and requested an ambulance and for the prison doctor to attend. This was logged as at 9.45am. The manager asked someone to bring a defibrillator (a life-saving device that gives the heart an electric shock in some cases of cardiac arrest) from the wing office.

73. A nurse arrived at 9.47am and examined the man, who was still unresponsive and had no pulse. The SO set up the defibrillator, which found no shockable heart rhythm and he and an officer took over resuscitation. A doctor arrived at the cell at the same time as the nurse. While the staff continued cardiopulmonary resuscitation, the doctor checked the man for signs of life. At 10.02am, he pronounced him dead. The doctor fully briefed paramedics who arrived at the cell at 10.07am.

Events after the man's death

74. The man's ex-cellmate told the investigator that he had not seen the man's recall papers when they shared a cell and that he had not mentioned them. He said that, after his death, other prisoners had told him that he had been informed that he would have to serve the remainder of his sentence in prison. The safer custody manager told the investigator that a SO, an offender supervisor, had signed for the recall pack on 22 March and it was to be delivered that day. He had not received the pack before he died.

75. After the man's death, prison staff found three letters dated 19 March in the prison postal system: two were addressed to his partner and one to a friend in another prison. He did not indicate in the letters any intention to take his own life.

Support for prisoners

76. The Governor issued a notice informing prisoners of the man's death and outlining the support available to them. All prisoners subject to suicide and self-harm prevention procedures were reviewed in case they had been adversely affected by the man's death. A prisoner told the investigator that he was offered support immediately after the man's death, but subsequently had trouble sleeping. He said that the healthcare team had refused to help him and, because he could not sleep, he had lost his prison job. The ex-cellmate also said that he had trouble sleeping for some time.

Support for staff

77. Around 12.30pm on 22 March, the duty governor held a debrief to support all the staff who had been involved in the emergency response. The staff care team visited the wing for further support.

Family Liaison

78. A prison chaplain acted as the prison's family liaison officer after the man's death. He was not in the prison at the time the man died but arrived at 11.15am. The duty governor and the Governor briefed him about the circumstances of the death. The man had listed his partner, who lived in Clacton on Sea, as his next of kin. The chaplain old the investigator that they checked the best route and the AA Route Planner advised that the journey would take two hours and 25 minutes. He was concerned that the journey might take longer as it was a sunny weekend and there would be heavier traffic at Dartford and Clacton.

79. As a result, the Governor contacted the duty governor at HMP Chelmsford, who agreed that one of their family liaison officers would inform the man's partner and let Elmley know, once this had been done. The Chelmsford family liaison officer arrived at the man's partner's house at 3.00pm, but as she was not there, he spoke to her by telephone. She arrived at 3.30pm and the family liaison officer informed her and the man's sister, who was with her, that he had died. He told them that the chaplain would contact them the next day. He informed Elmley at 4.10pm that he had informed her.

80. The man's partner telephoned Elmley later that evening and the chaplain spoke to her at 10.43pm. His partner was upset and said that she had spoken to him on the phone and he had given her no indication that he intended to kill himself. The chaplain spoke to her for some time and offered to meet her with the Governor. They spoke again the next day. He also spoke to the man's aunt and uncle. They discussed the Coroner's inquest and the funeral

arrangements. Elmley held a memorial service for the man at the prison on 25 March. The prison offered financial assistance towards funeral costs in line with Prison Service guidance. The funeral was held on 25 April.

Post-mortem report

81. The post-mortem examination concluded that the cause of the man's death was by suspension.

ISSUES

Assessing risk or suicide and self-harm

82. Prison Service Instruction (PSI) 64/2011 (Safer Custody), and PSI 74/2011 (Early Days In Custody), both list a number of risk factors and potential triggers for suicide and self-harm. These include a range of factors such as early days in custody, impulsiveness, previous self-harm, being charged with a violent offence (particularly against a family member), licence recall and a history of mental health problems. All staff who come into contact with prisoners are expected to be aware of these risk factors. PSI 74/2011 requires new prisoners to be interviewed in reception to assess the risk of self-harm and states that all staff should be alert to the increased risk of suicide and self-harm posed by prisoners in those categories and act appropriately to address any concerns, including opening an ACCT if necessary.

83. Staff judgement is fundamental to the ACCT system. The system relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. It is not an exact science.

84. We have considered whether reception staff at Elmley should have identified the man as at risk of suicide and self-harm and opened an ACCT to help ensure that he was appropriately supported. It was recorded on his escort record that he suffered from anxiety and depression and had been recalled to prison. When he was asked directly he said that he had no current thoughts of suicide or self-harm and when he was in police custody, he said that he had never self-harmed. He also said this to the prison reception nurse. However, he had self-harmed in prison in December 2008. While this information was not available from his escort record, prison reception officers could have obtained it from his electronic prison record. The reception officers did not record that they had asked him about his history of self-harm and there is no evidence that they checked his previous records.

85. The man was a licence recall prisoner, suffered from anxiety and depression and had a history of self-harm (albeit some time previously.) These are all significant indicators that he was at increased risk of suicide and self-harm. However, it is not apparent that these factors were taken into account by prison staff who assessed his risk of suicide and self-harm when he arrived. There is no record that they considered his risk factors. While it is possible that staff might still have concluded that it was not necessary to open an ACCT, we are concerned that staff seemed to have relied heavily on is presentation rather than his known risk factors, when he arrived at Elmley. We make the following recommendation:

    The Governor should ensure 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.

86. In his short time at Elmley, the man had several interactions with members of probation staff at Elmley and with staff from Ilford probation office. On 12 and 14 March, he saw the prison probation officer to discuss his recall and on both occasions he was tearful, distressed and agitated. On the second occasion, he asked to be referred to the mental health team and said he found it difficult to cope in custody. The probation officer was also aware that his OASys report had indicated that he had previously suffered from depression and anxiety and there was concern in January 2014, that he might harm himself. He told the investigator that, with hindsight, he should have opened an ACCT at his meeting on 14 March but had been reassured when the mental health team told him that afternoon that they had already received a referral for the man.

87. The man spoke to his community probation officer on 17 March. By this time he had been in prison for a week and pleaded with her to help him get released. She told the investigator that she had been his probation officer for three years and, based on her knowledge of him, she was not overly concerned about his presentation during their conversation. She said that he had usually been anxious, was no different on this occasion, and that she did not consider that he was at risk of suicide or self-harm.

88. When the man spoke to a senior probation officer at Ilford on 21 March, he was frustrated that he still had not received his recall pack and told her that his relationship with his partner had ended. He sounded distressed and anxious during their conversation and she acknowledged the difficult challenges he faced. However, she did not make a note of the conversation before starting a long period of sick leave. There is no record that she spoke to anyone at Elmley after the conversation.

89. We have listened to the telephone calls, and consider that the man gave enough information that should have alerted the senior probation officer to consider that he might be at risk of suicide and self-harm and to have warned prison staff about his state of mind. He was still unsure about his recall status, very anxious about being prison and told her that his relationship had broken down.

90. There were also several other opportunities for prison staff to have further considered the man's risk of self-harm or suicide. On 12 March, a prison probation officer emailed a copy of his OASys record to staff on his houseblock, highlighting that he might be at risk. We have not seen any evidence that action was taken as a result, and no record was made in the wing observation book as she had requested. On 14 March, his standard recall notice was sent to the prison and included a warning that he was vulnerable and might harm himself. Again, no action was taken after this information was received. Prison Service Instruction 64/2011 which governs ACCT procedures, contains a mandatory requirement that any member of staff who receives information, including from family members or external agencies, which might indicate a risk of suicide and self-harm must open an ACCT. We are concerned that probation staff did not pass some information about the risk to the prison and that other information was not acted on. We make the following recommendation:

The Governor of Elmley and the National Probation Service London Division should ensure that probation staff take into account and record all known risk factors and triggers when assessing a prisoner's risk of suicide or self-harm, that they share any concerns about a prisoner's state of mind urgently with prison staff and that prison staff open an ACCT when appropriate.

Healthcare assessments

91. The clinical reviewer concluded that the clinical care the man received at HMP Elmley was comparable to the care he could have expected to receive in the community. He noted that the man's reception health screen on 10 March was satisfactory and the nurse appropriately referred him to the mental health team. He considered that the mental health team had not missed any opportunities for intervention and could not have foreseen the need for more urgent medical intervention.

92. However, we are concerned that no action was taken after the prison probation officer referred the man to the mental health team again on 14 March. This was a missed opportunity to assess his mental health and might have helped identify whether he poised any significant risk of suicide and self-harm. Mental health team staff we spoke to appear to have considered the probation officer's referral duplicated that made by the reception nurse. However, it identified new issues and concerns which they should have taken into account. It was apparent that not all the healthcare staff fully understood how to use SystmOne, the electronic medical record system, which might have added to the confusion. We make the following recommendation:

The Head of Healthcare should ensure that mental health staff review and consider each referral individually and record the outcome of each referral on SystmOne.

The man's recall to prison

93. Probation officers have a difficult task and heavy responsibility when supervising offenders released on licence. They must put public protection at the forefront when reaching decisions about whether to recommend that an offender is recalled to prison.

94. The man had been released from prison for only week yet probation staff already had a number of concerns about him. On 7 March, he had a drug test at the approved premises which subsequently indicated that he had used drugs. When, later on the morning of 7 March, his partner told the senior probation officer that he had been using class A drugs and had threatened to kill her (although his partner said she told her that if they did not do anything to help him and he did cut her throat, her blood would be on their hands), the senior probation officer was rightly concerned. She later reported what she had been told to the police. He went to the police station voluntarily but was arrested by the police for questioning and later recalled to custody.

95. The detailed reasons for the man's recall, and what he was actually told about his recall, are less clear. The senior probation officer told the prison probation officer that he had been recalled because of concerns about his behaviour. His recall paperwork, however, listed the only reason as "failed to reside as approved". This was because he had not kept to his curfew which he had not been able to do as he was in police custody at the time. It is not clear that anyone told the approved premises that he was in police custody when he failed to return at his curfew time and it is possible the recall was originally initiated on a misunderstanding or because of poor communication.

96. The senior probation officer told the man that at the time of his recall she had been concerned about him as he had failed a drug test on 7 March and his partner had said he had threatened her. While we understand that the probation staff had grounds to be concerned about him, there was a lack of clarity of reasons for the decision and a failure to give him clear reasons on which he might base an appeal. The original licence revocation of 8 March stated that he "would receive more detailed reasons once you have been returned to custody". We do not consider that this was ever done. We make the following recommendation:

The National Probation Service London Division should ensure that all prisoners recalled to prison receive detailed reasons explaining the decision.

97. It is clear from the man's conversations with officers, probation staff, his partner and other prisoners that he was concerned about his recall and not sure about how long he would have to stay in prison.

98. On the order which revoked his licence, which was signed on 8 March 2014, the man was told that the public protection casework section of the National Offender Management Service would confirm the reason why he had been recalled, the information on which this was based and how to appeal. He was told on the order that he should ask prison staff to contact the casework section if he had not received this information within five days of being back in prison.

99. A clerk chased the recall paperwork on 14 March. The public protection casework section sent the recall paperwork on 17 March – nine days after the man had been returned to custody – and the clerk confirmed that he had received it the following day. On the cover sheet, the public protection casework section stressed that the papers should be given to the prisoner within one working day, and that the form notifying them whether the man intended to appeal should be returned to them within five working days from the date of the letter (17 March).

100. The clerk told the investigator that once he received the recall pack, he put it in a folder for an officer to take to the man's houseblock. However, there is no assigned officer to do this. The safer custody manager told us that a SO signed for the pack on the day of the man's death, so he had not received it when he died, 14 days after he was returned to prison and nine days after the

date he should have received it by. Being recalled to prison is a vulnerable time for prisoners and it is important that the system works effectively so that prisoners are informed of the full reasons as quickly as possible so that their risk of suicide and self-harm is not exacerbated. We make the following recommendation:

The Governor should ensure that recall documents are issued to prisoners within the expected timeframe.

Roll checks and unlocking cells

101. For their own safety, officers are expected to make contact with a prisoner through the observation hatch before opening a locked cell door. When unlocking a cell they should take active steps to check on a prisoner's wellbeing. The Prison Officer Entry Level Training (POELT) manual states that "Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead".

102. Officer B unlocked the man's cell at about 9.15am. We were not able to speak to him to ask if he had checked the man when he unlocked his cell but he did not say that he had seen him at that time in his prison statement. Officer A told the investigator that he did not think that staff need to get a response from prisoners because it would take too long to unlock. We cannot be sure whether Officer B checked that the man was alive when he unlocked the cell, but the evidence does not suggest that this was done. We make the following recommendation:

The Governor should ensure that, when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.

Emergency response

103. Three officers responded immediately when a prisoner told them that there something was wrong with the man. Officer C pressed the general alarm when they found him hanging and Officer B radioed an urgent message and gave full details of the incident. The officers did not radio a code blue emergency as national and local instructions require. This should have triggered the control room to call an ambulance immediately but this was not done until a unit manager requested one five minutes later.

104. Prison Service Instruction 3/2013 (issued February 2013) requires that governors 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, ensure 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. Elmley has a local procedure which reflects this. However, both in this case and in five other investigations at Elmley since 2012, we have found that an ambulance was not called immediately in an emergency as it should have been. Issuing a new protocol does not appear to have changed staff practice and it is unacceptable that prison managers do not appear to have conveyed the importance of this emergency procedure to prison staff. We make the following recommendation:

The Governor should make active efforts to ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including the appropriate use of emergency codes to ensure there is no delay in calling an ambulance.

Informing the man's family of his death

105. Prison Service Instruction 64/2011, which covers safer custody issues, usually requires a family liaison officer and another member of staff to visit a prisoner's next of kin in person to break the news of a death. Where the prison is a long distance from the prisoner's family, they can consider asking a family liaison officer from a nearer prison to inform them to avoid undue delay.

106. The man was pronounced dead at 10.02am and a family liaison officer was appointed shortly afterwards. However, because of the distance and concerns about delay, Elmley decided to ask HMP Chelmsford to break the news of his death. They informed his partner at about 3.30pm.

107. While Chelmsford was much closer to the man's partner's home than Elmley, we do not consider that there was much, if any, time advantage in asking someone from Chelmsford to break the news. The difference in journey time for each prison was just over an hour, which was likely to have elapsed while Chelmsford and Elmley arranged and briefed a family liaison officer to visit. Staff from Elmley could easily have reached her home by 3.00pm which is the time that the family liaison officer from Chelmsford got there. Although we understand that Elmley was trying to ensure that the next of kin was informed as quickly as possible, this aim was not achieved. It also meant that his partner was unable to ask questions directly of staff from Elmley. We make the following recommendation:

The Governor should ensure that, in line with PSI 64/2011, the next of kin are informed as soon possible after a prisoner's death and, where possible, by staff from the prison.

Support for prisoners after the man's death

108. A prisoner, who along with the man's ex-cellmate, found him hanging, told us that staff supported him well in the immediate aftermath of his death. However, they said that they had continued trouble sleeping. The prisoner said that, despite asking, he did not receive help for this for some time.

109. PSI 64/2011 requires prisons to have procedures to support prisoners who have been affected by a death in the prison. It appears that prisoners were appropriately supported at the time of the man's death but we are concerned that the prisoner's experience suggests that this was not prolonged and he was not able to get additional help when he needed it. We make the following recommendation:

The Governor and Head of Healthcare should ensure that prisoners who have been affected by a death in the prison receive effective ongoing support for as long as it is required.

RECOMMENDATIONS

1. The Governor should ensure 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.

2. The Governor of Elmley and the National Probation Service London Division should ensure that probation staff take into account and record all known risk factors and triggers when assessing a prisoner's risk of suicide or self-harm, that they share any concerns about a prisoner's state of mind urgently with prison staff and that prison staff open an ACCT when appropriate.

3. The Head of Healthcare should ensure that mental health staff review and consider each referral individually and record the outcome of each referral on SystmOne.

4. The National Probation Service London Division should ensure that all prisoners recalled to prison receive detailed reasons explaining the decision.

5. The Governor should ensure that recall documents are issued to prisoners within the expected timeframe.

6. The Governor should ensure that, when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.

7. The Governor should make active efforts to ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including the appropriate use of emergency codes to ensure there is no delay in calling an ambulance.

8. The Governor should ensure that, in line with PSI 64/2011, the next of kin are informed as soon possible after a prisoner's death and, where possible, by staff from the prison.

9. The Governor and Head of Healthcare should ensure that prisoners who have been affected by a death in the prison receive effective ongoing support for as long as it is required.

PRISONS AND PROBATION OMBUDSMAN for England and Wales

Independent Investigations

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 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.	Accepted	Reception staff have been instructed to ensure that all documentation available at the time of reception is considered when assessing the risk of self-harm or suicide.	Completed Head of Safer Custody	
2	The Governor of Elmley and the National Probation Service London Division should ensure that probation staff take into account and record all known risk factors and triggers when assessing a prisoner's risk of suicide or self-harm, that they share any concerns about a prisoner's state of mind urgently with prison staff and that prison staff open an ACCT when	Accepted	This case will be discussed at the NPS London Suicide Prevention Forum and lessons learned will be identified and shared appropriately. An e-mail will be sent to all NPS London staff reminding them of their responsibility promptly to share information with the relevant prison where there are any concerns regarding a risk of suicide or self-harm.	February 2015 NPS London Suicide Prevention Forum Chair February 2015 NPS London Lead for Deaths Under Supervision	

	appropriate		All prison staff have been instructed to open an ACCT whenever they receive information that indicates a risk of self-harm or suicide. The circumstances in which an ACCT must be opened, and the process for doing so, are covered in the Introduction to Safer Custody training that is undertaken by all staff who have contact with prisoners. Refresher training is also provided to ensure that staff are regularly reminded of the circumstances in which it is appropriate to open an ACCT.	Completed Governor	
3	The Head of Healthcare should ensure that mental health staff review and consider each referral individually and record the outcome of each referral on SystmOne.	Accepted	Healthcare staff have been instructed to ensure that all referrals are acted upon, and that SystmOne is updated with the outcome in each case.	Completed Head of Healthcare	
4	The National Probation Service London Division and NOMS Offender Management & Public Protection Group should ensure that all prisoners recalled to prison receive detailed reasons explaining the decision.	Accepted	NPS London and NOMS OMPPG will review current processes and ensure that in 'out of hours' recall cases there is a checking process in place to ensure consistency in the reasons given between the original request for the recall, the breach report sent by the NPS London offender manger to NOMS OMPPG and the recall dossier provided by NOMS OMPPG to the offender. NOMS OMPPG will issue the dossier to the offender within the target of 24 hours from return to custody, outlining full reasons for their detention and advising them of their right to make representations to the Parole Board in relation to their ongoing detention.	March 2015 Head of Post Release Casework – PPCS/OMPPG	
5	The Governor should ensure that recall documents are issued to prisoners within the	Accepted	Offender Management Unit staff will be instructed to ensure that all recall documents are issued to prisoners within one working day of receipt at the	March 2015 Deputy Governor	

	expected timeframe		prison. A management check will be put in place to ensure compliance.		
6	The Governor should ensure that, when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.	Accepted	Residential staff have been instructed to assure themselves of the wellbeing of prisoners during or shortly after the unlocking process.	Completed Head of Residence	
7	The Governor should make active efforts to ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including the appropriate use of emergency codes to ensure there is no delay in calling an ambulance.	Accepted	All staff have been reminded of the emergency code system and what their responsibilities are in a medical emergency. A memorandum of understanding about the handling of medical emergencies at the prison has been introduced between South Coast Ambulance Trust and HMP Elmley.	Completed Governor	
8	The Governor should ensure that, in line with PSI 64/2011, the next of kin are informed as soon possible after a prisoner's death and, where possible, by staff from the prison.	Accepted	The contingency plan for deaths in custody will be updated to make it clear that Elmley staff should inform the next of kin unless this will cause unnecessary delay, in which case assistance will be sought from another prison and/or the police as appropriate.	March 2015 Governor	
9	The Governor and Head of Healthcare should ensure that prisoners who have been affected by a death in the prison receive effective ongoing support for as long as it is required.	Accepted	The contingency plan for deaths in custody has been updated to make it clear that cellmates and known associates of the deceased should be offered support by staff. These prisoners will be made aware of the availability of Listeners and relevant healthcare professionals and informed about how to access them in the future should they need to do so.	March 2015 Governor	