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 in August 2013 at HMP Wealstun

Final Report: Mr Robert Majchrzak: Date: October 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 on 6 August 2013 at HMP Wealstun. The man died in his cell from smoke inhalation. He was 33 years old. I offer my condolences to the man's family and friends.

The investigation was carried out by an investigator. Two clinical reviewers reviewed the clinical care the man received in custody. Wealstun cooperated fully with this investigation.

The man was remanded into custody on 29 February 2012. He was convicted of arson and robbery on 28 May 2012 and given a 40 month sentence. The man had been in prison before. He suffered from a mental illness for which he was prescribed medication and also had a history of self-harm. In prison, he was supported under suicide and self-harm procedures on several occasions. He sometimes made accusations that he was being bullied or mistreated by other prisoners but would often then retract what he had said, making it difficult for prison staff to investigate. On 30 July 2013, he told the instructor in his workshop that he was being bullied on his wing. The safer custody team investigated and found that this had not been the case. On 31 July, the man told a prisoner peer support worker that he was feeling suicidal. The other prisoner was very concerned and told an officer, but the officer did not begin suicide and self-harm prevention procedures. Staff on duty on the night of 5 and 6 August detected an unusual smell on the wing and made some investigation, but did not check the cells. Night patrols appear to have missed the man's landing. On the morning of 6 August, during a roll check, the man was found unresponsive in his cell which was full of smoke. Sadly, it was clear that the man had been dead for some time.

The clinical review found that the man received a good standard of mental health support at Wealstun. However, I am concerned that a prisoner with a history of self-harm and attempted suicide was not properly supported after he said he had suicidal thoughts shortly before he died. While some of the allegations he made about his treatment by other prisoners might have been symptomatic of his mental health problems, each seems to have been treated in isolation and more coordinated consideration might have helped identify better what the problem was, and whether the man needed additional support. On the night he died, I am concerned that officers did not investigate sufficiently the cause of the smell on C wing.

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 **October 2014**

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SUMMARY

1. The man had a history of mental illness, including schizophrenia for which he was prescribed medication. He also had learning difficulties and was diagnosed with personality disorder. He had a history of self-harm and had previously attempted suicide in 2006, while in the community, by taking an overdose of medication. The man had been in prison before.

2. On 29 February 2012, the man was remanded to HMP Leeds charged with arson and robbery. On 28 May, he was convicted and sentenced to 40 months in custody, with a release date of 28 October 2013. He transferred to HMP Wealstun on 6 July.

3. Members of the mental health team, prison doctors and a psychiatrist at both Leeds and Wealstun assessed the man and prescribed medication. The man said on several occasions that he had thoughts of harming himself and prison staff managed him under Prison Service suicide and self-harm prevention measures known as ACCT. The ACCT monitoring ended after staff assessed that he was no longer at risk of suicide and self-harm. The last ACCT was closed on 24 June 2013.

4. On 30 July 2013, the man told another prisoner that he had thoughts of taking his own life. The prisoner told an officer, who did not open an ACCT.

5. During the early hours of 6 August, officers on the man's wing smelled what they described as a chemical smell. They briefly checked the wing, including the cleaning cupboard, but did not check each cell. They could not find the source of the smell and they did not see any smoke.

6. At 7.10am, an officer conducting a roll check found the man's cell full of smoke and raised the alarm. Officers got the man out of the cell but it was clear that he was dead. Paramedics arrived and confirmed that the man had been dead for some time.

7. We are satisfied that the mental health care that the man received at Wealstun was comparable to that he could have expected in the community. However, we are concerned officers did not begin ACCT procedures after the man said he intended to end his own life, a few days before his death. We cannot know whether this would have changed the outcome for the man but, had his risk been identified, it would have meant he was monitored more frequently during the night of 5/6 August and it is possible that officers could have dealt with the fire at an earlier stage. Not enough was done to establish the cause of the smell on the wing on the night the man died. We make six recommendations.

THE INVESTIGATION PROCESS

8. The investigator issued notices to staff and prisoners at Wealstun, informing them of the investigation and inviting anyone with relevant information to contact him. No one responded.

9. The investigator visited Wealstun on 9 August and obtained copies of the man's prison and healthcare records. He subsequently interviewed eight members of staff and four prisoners at Wealstun. Two clinical reviewers reviewed the man's clinical care on behalf of NHS England.

10. After the man's death, West Yorkshire Police investigated the actions of some of the prison staff at Wealstun. In line with our agreement with the police, our investigation was suspended until the police had completed their enquiries. We are sorry for the consequent delay in issuing this report.

11. The Crown Premises Investigation Group (CPIG), which is responsible for the enforcement of the fire safety on Crown property, also conducted an investigation. The investigator liaised with CPIG frequently during the course of this investigation.

12. We informed the local coroner of the investigation and have sent him a copy of this report.

13. One of our family liaison officers contacted the man's family to explain the purpose of the investigation and gave them the opportunity to raise any matters they wanted the investigation to consider. The family liaison officer and the investigator met the man's family on 9 October. His family had a range of questions about whether he was being bullied, his medication, his monitoring as a risk of suicide and self-harm, the materials in his cell, the circumstances of the fire which led to his death and fire prevention procedures at the prison. We have taken his family's questions into account in this report. The man's family received a copy of the draft report. They raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

HMP WEALSTUN

14. HMP Wealstun is a Category C prison, near Wetherby, which can accommodate up to 832 men. Leeds Community Healthcare NHS Trust provides primary care and substance misuse services. Outside normal working hours, 7.30am to 6.00pm, medical advice is available from NHS Direct or an out of hours GP service.

Her Majesty's Inspectorate of Prisons

15. The last inspection of Wealstun was in August 2011, when inspectors found that relationships between staff and prisoners were variable and poor behaviour was too often left unchallenged. The level of self-harm was not high and the quality of assessment, care in custody and teamwork (ACCT) documentation was generally acceptable. The Samaritans provided ongoing and effective training and support to Listeners (prisoner peer supporters) and confirmed that prisoners had full access to Listeners. Mental health services were assessed as good with effective liaison between the mental health nurses and the doctors.

Independent Monitoring Board

16. 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. The Wealstun IMB has not produced an annual report for the past five years.

Assessment, Care in Custody and Teamwork

17. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. The purpose of the ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. An ACCT should be opened immediately, and by any member of staff, when there are concerns that a prisoner is at risk of suicide or self-harm.

18. Checks should not be at predictable 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.

Previous deaths at Wealstun

19. The PPO has investigated four deaths at Wealstun, before the man's death in August 2013. Since then we have investigated one more. There were no similarities with the circumstances of the man's death.

KEY EVENTS

HMP LEEDS

20. On 29 February 2012, the man was remanded to HMP Leeds, charged with arson and robbery. The man had a learning disability and suffered from personality disorder and schizophrenia. He had a history of self-harm and had previously attempted suicide in 2006 by taking an overdose of medication. The man had been in prison once before.

21. When he arrived at Leeds, he told a nurse at an initial healthscreen that he was under the care of St Mary's Hospital, Leeds, for schizophrenia and split personality disorder. The man said that he believed his next fortnightly injection of antipsychotic medication was due on 9 March. The nurse recorded that the man had no concerns about his physical health and had no thoughts of suicide or self-harm. The nurse referred him to the mental health team.

22. On 1 March, a nurse from the mental health team, saw the man and recorded that his medication was pipothiazine palmitate (for schizophrenia) and that he said he had no thoughts of suicide or self-harm. Later that day a prison doctor, received confirmation from the man's community doctor that he received depot injections every two weeks. (A depot injection slowly releases antipsychotic medication into the body over a number of weeks.) He received his next injection on 5 March.

23. Between 2 March and 22 March, a nurse reviewed the man's mental health three times. The nurse recorded that the man was concerned about his father's health, but had settled at the prison and had no thoughts of suicide or self-harm. He received a depot injection on 19 March.

24. On 23 March, an officer opened an ACCT after the man harmed himself by cutting his left arm. The man was at regarded as at raised risk of suicide and self-harm. The level of observations was set at hourly and officers removed razors from his cell to help prevent him cutting himself again.

25. On 25 March, a Supervising Officer (SO) held the first ACCT case review. An officer attended but there was no one from the healthcare team which is a mandatory requirement for first ACCT case review. The man said that he was stressed because this was the second time he had been in prison. He said that, because of his mental illness, he wanted to be sectioned under the Mental Health Act and transferred to a secure psychiatric unit. Otherwise, he said he would kill himself by wrapping a blanket around himself and setting fire to it. The man said that he did not receive visits from anyone. The SO spoke to the mental health team to ensure that they would review the man.

26. The SO completed an ACCT caremap to support the man. The caremap documented that the man was to continue to engage with the mental health team and was told how to access the Samaritans. The review assessed him as still at raised risk of further self-harm and kept the level of observations at hourly.

27. On 26 March, the man told the nurse that he had cut himself as a means to reduce tension. He said that he occasionally heard voices which told him to

harm himself, that his medication was no longer helping him and he wanted to be admitted to hospital. The man said that his cell mate was good to him but other prisoners made fun of him. The nurse noted that she would discuss the man's care with a visiting psychiatrist, when he was next at the prison on 29 March.

28. On 29 March, an SO held an ACCT review. Another SO was present, but there was no representative from the healthcare team and they had not been contacted in advance. The man said that he had settled at the prison and the mental health team and other prisoners were supporting him. He said that he no longer had any thoughts of suicide or self-harm. His risk of self-harm was assessed as low and the ACCT was closed.

29. Later on 29 March, the nurse and the psychiatrist saw the man and recorded that he was much brighter and appeared less troubled. The psychiatrist recorded in the man's record that, as there had been an improvement in his mood in the past week, and no further incidents of self-harm, he did not need a change in his medication. The man was to continue to receive support from the mental health team.

30. Between 30 March and 27 May, healthcare staff reviewed the man's mental health ten times and he gave no indication of thoughts of suicide or self-harm. He continued to receive his prescribed depot injection every fortnight.

31. On 15 April, the man told a workshop officer that other prisoners were "winding him up" and that he would soon hit someone. The officer spoke to him about this and the man said that other prisoners had been teasing him, but he recognised that they were only having fun and that he took it too much to heart. He said that he had since made friends with these prisoners and he wanted to keep his job in the workshop. No further action was taken.

32. On 28 May, the man was convicted and sentenced to 40 months in prison. His release date would be 28 October 2013. On 29 May, a nurse reviewed the man because of his court appearance the previous day. The man said that he was coping with the sentence he had received. The nurse requested that, if the man transferred from Leeds after his sentence, he should go to HMP Wealstun which would allow him to remain under the psychiatrist's care.

33. Between 30 May and 5 July, the man had four more mental health reviews. No concerns were identified about his risk of suicide or self-harm. He continued to receive his fortnightly depot injection.

HMP Wealstun 2012

34. On 6 July 2012, the man transferred to HMP Wealstun. A nurse conducted an initial health screen and recorded that the man suffered from mental illness and had a history of self-harm, with the last incident at Leeds in February. The man said that he had no concerns and was happy to be at Wealstun. Later that day, the officer completed the man's induction. The man said that he had self-harmed in Leeds because he was stressed, but now he felt fine and no longer had thoughts of self-harm.

35. On 9 July, a member of the mental health team, saw the man in his cell. The nurse recorded that the man was watching television and appeared happy and calm. The man said that he did not hear voices and had no thoughts of suicide and self-harm. He said that he recognised when he started to become unwell as he began to shout and "do stupid things".

36. On 10 July, the psychiatrist and a nurse saw the man who was calm and reiterated that he was not hearing voices. The psychiatrist explained that the pharmacy had been unable to obtain pipothiazine palmitate from either the wholesaler or the manufacturer and discussed alternative treatment options. The psychiatrist prescribed flupentixol (an antipsychotic and antidepressant), and gave an initial dose that day, to be followed by one in seven days and fortnightly afterwards until further supplies of pipothiazine palmitate could be obtained. The psychiatrist also prescribed procyclidine (for side effects of antipsychotic medication) to be given daily in tablet form.

37. On 11 July, a nurse saw the man to discuss his care for his remaining time in prison and his plans for when he was released. The man said that he intended to go back to live in Leeds, but had no accommodation and was contacting Shelter for help. He said that he was registered as disabled and before he went to prison had been receiving Disability Living Allowance and Employment Support Allowance.

38. Between 12 July and 10 September, the man had one mental health review and was treated three times for stomach pain and diarrhoea. The man continued to receive his fortnightly medication by injection. He received an injection on 29 August.

39. On 11 September, the nurse opened an ACCT after the man had gone to the healthcare centre for his depot injection and had said that he had thoughts of killing himself because he felt unable to cope. He said his father was dying and he wanted to be "sectioned" to a psychiatric hospital. An immediate action plan indicated he should be observed every 15 minutes. He declined offers to telephone his family or the Samaritans. He was made aware of the Listener service.

40. At 5.00pm, a nurse gave the man his depot injection. The man said he thought that he should be sectioned as he felt unable to cope in prison as he had panic attacks in his cell. He said that he was not being bullied and had friends on the wing but that he felt uncomfortable in the presence of others. The nurse recorded that the man was already on an ACCT and was receiving support from the nurse and the psychiatrist.

41. At 5.40pm the same day, an officer interviewed the man for an ACCT assessment. The man said that he was depressed because of his father's health and had thoughts of taking his own life. He said he was happy to have the support of the mental health team and wanted to use the gym. The officer offered the services of the Samaritans, Listeners and the chaplaincy but the man declined.

42. At 5.50pm, an SO held the first case review. The officer attended but there was no one from the healthcare team present, a mandatory requirement for first case reviews. The man said that he felt better than he had earlier, but was still

worried about his father. He said he knew that he had support from officers and the Listeners. The SO recorded that a member of the mental health team was to attend the next review.

43. The SO completed an ACCT caremap with goals for the man to continue to engage with the mental health team and attend the gym. The review assessed him as still at raised risk of further self-harm. The level of observation was set at one each morning, afternoon and evening and hourly throughout the night until the next ACCT review.

44. On 13 September, another SO held an ACCT review, which the nurse attended. The man said that he felt much better but was concerned that he was not on the correct medication. The review assessed that the man was at low risk of suicide and self-harm and set the level of observations at one each morning, afternoon and evening. Observations at night were reduced to every two hours.

45. On 18 September, an SO, the nurse and an officer held another ACCT review. The SO recorded that the man appeared to be under the influence of drugs at the review. He was concerned that the man might have taken some illicit drugs as well as his prescribed medication. His risk of self-harm was assessed as raised and observations were increased to hourly throughout the day and night.

46. On 19 September, the nurse saw the man and recorded that he appeared more settled. The man said that he was still anxious about his father's health but did not have any thoughts of suicide and self-harm. He said that he had not taken any illicit drugs.

47. During the morning of 21 September, officers were concerned about the man's mood and contacted the nurse. At approximately 11.00am, two nurses went to see the man in his cell who told them he had sexual thoughts about a female officer. He said he was fed up and had thoughts of harming himself but no plans to act on them. The nurse noted that were would be an ACCT review later that afternoon and he would recommend that the man should transfer to another wing.

48. At 12.35pm, an officer answered the man's cell bell and the man said that he wanted to see the nurse as he felt like killing himself. The officer told the man to relax and watch television until lunch had finished and that he would ask the nurse to come and see him.

49. At 1.00pm, the man pressed his cell bell again. This time the officer answered and found the man standing in his cell with a ligature, made from bedding, loose around his neck. It appeared that he had tried to hang himself. Officers immediately went into the cell. The man was conscious and was able to speak to them. A code blue (which indicates a medical emergency for circumstances such as when someone is unconscious or has breathing difficulties) was called and he was placed in the recovery position.

50. A nurse responded to the emergency code and the man said that he had taken some medication that had been prescribed for another prisoner. He was taken to Harrogate Hospital where tests showed that he had not taken any illicit drugs or any medication he had not been prescribed. While he was at the hospital, at

8.30pm, he told one of the escort officers that he would try to take his own life if he was left alone that night. He also said that he would want to kill himself if his father died.

51. At 9.30pm, the man was discharged from hospital and returned to Wealstun. The man was placed in the care suite (an adapted cell with a gated door) and was accompanied by a Listener. The records show that the level of observations were “changed to hourly” while he was in the cell with the Listener, although that is the level that had previously been set.

52. At 10.30am on 22 September, an SO held an ACCT review which another SO a prisoner Listener attended. No one from the healthcare team was present. The man said he was thankful that he had not taken his life the previous day. He said that he had taken the ligature off once he realised what he was doing and that he had lied about taking another prisoner’s medication. He said he was having violent sexual thoughts about a female officer on his wing and he was worried that he might act on them. The man said that he did not think that his medication was working and he wanted it reviewed.

53. The review assessed that the man was at low risk of suicide and self-harm. The level of observation was reduced to one observation each morning, afternoon and evening, then hourly throughout the night. The man was moved to C Wing.

54. Later that afternoon, a nurse visited the man to see how he was getting on. He said that he was more settled but the lead up to his suicide attempt had been unbearable. The man told her that other prisoners had forced him to perform oral sex on them. The nurse noted in the medical records that the officer had reported this to the safer custody department. An SO investigated this and the man told him that one of the prisoners had asked him for oral sex but he had refused and left the cell. He said that another incident had happened in the showers. He said that he had been frightened at the time but did not want any further action taken. The man was no longer on the same wing as the other prisoners and he retracted what he had originally said. He signed a disclaimer to say that he did not want the matter referred to the police.

55. On 24 September, the man had a blood test for illicit substances. The results were negative. That afternoon, the nurse went to see the man in his cell. The man told him that he had not taken an overdose on 21 September, but had heard voices. He said that he did not have any plans to harm himself. The nurse noted that the man looked dishevelled and had a tremor in his right arm.

56. On 25 September, the nurse went to see the man again. The man said that he felt “OK” but he was still hearing voices and had difficulty sleeping. He said that he did not know why he made threats of inappropriate sexual behaviour towards a female officer. The nurse recorded that the man had no plans to harm himself. The man’s medical records confirm that he began to receive pipothiazine palmitate again that day.

57. On 26 September, the SO held another ACCT review which the nurse attended. The man said that he was hearing voices that told him to harm himself or others. The review noted that he was due to see the visiting

psychiatrist in the next few days and assessed that he was at low risk of self-harm. The level of observation remained unchanged.

58. The nurse saw the man on 27 September and 1 October. Both times the man said that he had no thoughts of harming himself. He had been socialising with other prisoners and playing pool. The nurse recorded that the man appeared more settled but thought that the ACCT should remain open.

59. On 1 October, the psychiatrist saw the man and noted that he gave an inconsistent account of recent events. He said he did not have any inappropriate sexual thoughts or thoughts of self-harm. The psychiatrist recorded that his assessment of the man's condition was that it was a combination of learning disorder, antisocial personality disorder and schizophrenia. He worked on the diagnosis that the man suffered from hypomania (periods of persistently elevated, expansive, or irritable mood, lasting throughout at least four days and present for most of the day). The doctor prescribed depakote and valproic acid (mood stabilisers) in addition to the fortnightly injection.

60. On 3 October, the SO and the nurse held another ACCT review. The SO recorded that the man was in better mood and looking forward to working in the workshops. The review assessed that the man was at low risk of self-harm and the meeting agreed that the level of observations could be reduced, although it is not clear from the records what level was set. .

61. The nurse saw the man on 5 and 8 October. The nurse recorded that there were no obvious signs that the man was in distress. He said that he had no thoughts of self-harm.

62. On 9 October, the SO held another ACCT review which the nurse attended. The man said that he enjoyed his job in the workshop, had no thoughts of suicide or self-harm and felt better about himself. The SO recorded that though the man was taking care of himself, his personal hygiene needed to improve. The review assessed the man as at low risk of self-harm and the level of observations was set at one quality observation and entry in the morning, afternoon and evening and hourly through the night.

63. On 17 October, the psychiatrist reviewed the man, who said that he would prefer to be in hospital as he did not feel able to cope in prison and also said he found it hard to cope in the community. He was worried that his father would die while he was in prison. He said he had no thoughts of self-harm. He said he had previously completed an NVQ in mechanics and would like to go to a prison to do mechanics. The psychiatrist recorded that the man was low in mood but not clinically depressed and had no overt psychotic symptoms. The psychiatrist made no changes to the man's medication.

64. On 23 October, the SO held an ACCT review with the nurse. The SO recorded that the man looked well and was going to work each day. The man said that he no longer heard voices and had no thoughts of self-harm or suicide. All caremap actions had been completed. It was agreed that the ACCT should be closed due to the improvement in the man's mental well being. A post-closure interview was scheduled for 30 October. Later that day, the man received a depot injection.

65. At 6.05pm on 27 October, an officer opened another ACCT as the man said that he felt very anxious. He was concerned at not being able to cope in prison and was worried about his father and feared he would kill himself if his father died. The immediate action plan was for observations to be undertaken every 30 minutes. The man was offered phone calls to the Samaritans and the support of a Listener but he declined.

66. At 8.55am on 28 October, the officer interviewed the man for an ACCT assessment. The man said that he was stressed because his father was dying. He said that he had no thoughts of suicide or self-harm and did not want to die and knew it would upset his family if he killed himself. The man agreed that he when he was feeling low he would ask to speak to a Listener or call the Samaritans.

67. At 3.30pm, an SO held the first ACCT review. The only other member of staff present was an officer. The assessor did not attend and neither did anyone from the healthcare team. The man said he was worried about his father's health and that it would kill him if his father were to die while he was in prison. He said that the mental health team supported him and that he would speak to the chaplaincy. The man said that he did not want his family informed that he was being managed under ACCT procedures because of his risk of suicide and self-harm.

68. The SO completed an ACCT caremap with goals for the man to continue to engage with the mental health team, maintain contact with his family and speak to the chaplaincy. The man was considered still to be at raised risk of self-harm. The level of observations was set at one each morning and afternoon and every two hours throughout the night.

69. On 29 October, the nurse went to see the man. He recorded that the man appeared settled with no signs of distress and had been taking his medication. The man said that both his sleep and diet were good and he had no thoughts of suicide or self-harm.

70. On 30 October, an SO held an ACCT review which the nurse and a member of the chaplaincy team, attended. The man said he was anxious about his father's health and wanted to make amends to him when he was released. He said he had no thoughts of suicide and self-harm. The review agreed to close the ACCT. On 6 November, the SO held an ACCT post-closure interview with the man. The man said that he had support from the mental health team, chaplaincy, staff and other prisoners and was looking forward to his release. He received a depot injection that afternoon.

71. At 10.45am, on 10 November, the officer opened an ACCT again as the man said that he felt very low and had thought about hanging himself. The immediate action plan, agreed with the SO, was for staff to observe the man at least once an hour. Staff encouraged him to speak to a Listener or call the Samaritans.

72. At 11.30am, an officer interviewed the man for the ACCT assessment. The man said he was unable to cope and wanted to be sectioned. He said his father was dying and he knew he would re-offend once he was released from

prison because he was a gambler. He said he did not know whether he wanted to die or not.

73. At 2.15pm, an SO and an officer held the first ACCT review without the required healthcare representation. The SO noted that the man had displayed some bizarre behaviour and it appeared that his mental health was deteriorating. The man said he was unsure if he was hearing voices. He did not want to kill himself and still wanted support from the mental health team. He said that he wanted to work as a painter and decorator when he was released.

74. The SO completed an ACCT caremap with goals for the man to continue to engage with the mental health team and for officers to support him. He was assessed as still at low risk. Observations were required at least once an hour day and night.

75. On 12 November, the nurse reviewed the man who said that he was tired as he had slept for only three hours because he had been hearing voices and was anxious about whether he would be able to cope for the remainder of his sentence. He said that he had no thoughts of harming himself. The nurse recommended that the man should be prescribed a short course of zopiclone for three days to help him sleep. A prison doctor, prescribed three zopiclone tablets, one to be taken at night.

76. On 14 November, the SO held an ACCT review but no one else was present. The man said that he was happy on C wing and had made friends he could talk to. He said that he knew he could talk to officers at anytime if he felt low. He said he had no thoughts of harming himself. The SO concluded that the man was at low risk of suicide and self-harm and reduced the level of observation to one each morning, afternoon and evening and every two hours during the night. On 15 November, the nurse saw the man who said that he had slept well and had no thoughts of harming himself.

77. On 19 November, the SO and the nurse held an ACCT review. The man said that he was settled on C wing and did not have any thoughts of harming himself. He said that he still wished to engage with the mental health team. The review agreed to close the ACCT. A post-closure interview took place on 26 November.

HMP Wealstun 2013

78. Between 27 November 2012 and 20 June 2013, the man had a total of 30 mental health reviews and continued to receive his medication as the psychiatrist prescribed. As well as mental health checks, healthcare staff also saw the man 14 times for general health matters during this period. He continued to attend workshops each weekday and used the gym.

79. On 20 June 2013, at 9.15am, the nurse opened an ACCT as the man said he was in low mood and wanted to harm himself. The immediate action plan, agreed with the SO was for the man to be observed once in the morning, afternoon and evening and every hour throughout the night. The man did not want to call the Samaritans or see a Listener.

80. At 10.45am, the officer interviewed the man for an ACCT assessment. The man said he was having flashbacks about the fire that he had started which had led to conviction and these flashbacks were disrupting his sleep. He thought he needed different medication and said that he did not want to die. The man said that he did not have a good relationship with his family because of his gambling.

81. At 11.05am, a Principal Officer (PO) held the first ACCT review. The SO and an officer were present but there was no one from the healthcare team at the review. However, the PO had spoken to a nurse before the review. The man said that he had thoughts of harming himself because he was frustrated about the level of his medication. However, he said he had no thoughts of killing himself.

82. The man had his depot injection later that day. He spoke to the nurse about his medication and agreed that he would discuss this with the psychiatrist who he was due to see the next week.

83. The PO completed an ACCT caremap with goals to continue to engage with the mental health team and for his medication to be reviewed by a GP. The man referred himself to the GP and the mental health in-reach team. The PO assessed that the man was still at raised risk of self-harm. The level of observations remained unchanged.

84. On 24 June, the SO held an ACCT review. Another SO attended but there was no one from the healthcare team and the SO had not contacted anyone for an update on the man's mental health. The man said that he had good support from officers and prisoners on the wing and had no thoughts of suicide or self-harm. The review concluded that the man was at low risk of self-harm and agreed to close the ACCT.

85. On 26 June, the psychiatrist reviewed the man. The man said that he was concerned about what would happen when he was released from prison and that all his medication would be withdrawn. The psychiatrist assured the man that there would be no change in his medication and he would liaise with the community psychiatric team before his release to ensure this. He did not identify any risks and the man's prescribed medication remained unchanged.

86. On 3 July, the SO held an ACCT post-closure interview with the man. The man said that he had the support of friends and officers and did not have any thoughts of suicide or self-harm. He enjoyed his job in the workshop and playing football. The man received his depot injections on 4 and 18 July as scheduled.

87. On 29 July, the nurse saw the man for a mental health review. The man said that he heard voices that he described as 'thoughts inside of my head'. He said that he had no problems with other prisoners and no thoughts of self-harm. He told the nurse that he had experienced difficulties sleeping for the previous week. The nurse recommended a short course of zopiclone. A prison GP, prescribed zopiclone for on 30 July.

88. On 30 July, the man told an instructor in the workshop where he worked, that he was being bullied on C wing but did not specify in what way. The instructor

passed this to the safer custody unit and the SO was asked to investigate. The SO found that the allegation appeared to be without foundation and some staff suspected that the man had made it up. The SO wrote on the safer custody report that “it was proved that this was a misunderstanding by both parties involved”.

89. During the early hours of 31 July, the man told a Listener that he had thoughts of taking his own life. The Listener was concerned about this and told the officer. He asked the officer to sign a written note he had made about his conversation with the man, but the officer did not open an ACCT. When she was interviewed, the officer told the police that, in response, she had gone to see the man, who she knew well. He told her that he wanted to move because another prisoner was intimidating him, and had turned the wing against him. The officer said that she would make a note of this request in the wing observation book. She said that the man was content with this. She told the police that that she was satisfied that there was no reason to open an ACCT.

90. As he was aware that the man had seen a Listener during the night, the nurse went to see him on the morning of 31 July. He told the nurse that he had made up allegations about being bullied and was looking forward to playing football that afternoon. However, he said that he felt anxious and asked for an increase in his medication. The nurse told the man that he would discuss this with the psychiatrist when he was next at the prison. The nurse recorded that the man did not have any thoughts of self-harm.

91. On 1 August, a member of the mental health team, reviewed the man, who again asked for his medication to be increased. He said he had no thoughts of suicide or self-harm but said he was becoming stressed about his forthcoming release in October. He received a depot injection later that day. The officer said she went to see him because of his allegation of intimidation the previous day. She said that he had told her that everything had been sorted and everyone was now his friend.

92. On 2 August, a nurse went to see the man at the request of officers. The man said that he felt anxious and angry and that he would assault someone if his medication was not increased. The man said that he was in debt to other prisoners on the wing for canteen items but otherwise felt safe. He said that he had no thoughts or plans to harm himself.

93. On 4 August, an SO noted in the man’s prison record that he had said that he was being bullied because he was bisexual. He said that he was not in debt but that everyone spoke about him. While they were talking, another prisoner came up to the cell to see if the man was all right. After he had gone, the man hinted to the SO that this prisoner was the one who was bullying him. The man said that he wanted to move to A wing as he feared for his safety. The SO said that he would look into this, but thought that it would be a bad idea to move. He noted in the prison record that he was unsure if any of what the man had said was true. Later that afternoon, the SO made another entry. He noted that the man had said that he was going to be killed by another prisoner and had been locked into his cell. However, he asked to come out after lunch and was seen talking amicably to the prisoner he had hinted was bullying him. The SO also submitted a safer custody report on 4 August. This was signed as being received on 6 August.

94. At around 2.00pm that afternoon, the man collected his medication from a nurse. He told her that he did not feel safe because some people were out to get him because of ""something [that] had happened". The nurse asked an officer who was nearby if he was aware of what this incident was. The officer said that he was aware but could not move the man, as it was the weekend. The nurse noted that she would ask another nurse for advice about this.

95. On 5 August, The nurse reviewed the man and recorded that he appeared more settled and was continuing to take his medication. The man told him that he was £10 in debt to another prisoner and that he had smoked a substance in the previous seven days, but did not know what it was. He said that he had no thoughts or plans to harm himself.

96. Three prisoners told the investigator that, in the days leading up to 6 August, the man's behaviour changed. They said that he became very paranoid and withdrawn, and was convinced that someone was out to get him, even though they told him that no one would hurt him. One prisoner said that he had spoken to the man on 5 August, before they were locked up for the night. The prisoner said that he and another prisoner had reassured the man that no one would hurt him and gave him some tobacco and a lighter. .

97. An officer and an operational support grade (OSG) were on duty on C wing from 7.30pm on Monday 5 August until 6.30am the next day. This was the Officer's first night shift at Wealstun.

98. The prisoner told the investigator that he had smelled what he thought was burning plastic at approximately 11.30pm. He said that he woke around 1.00am to 2.00am and could still smell it. Another prisoner said that he had woken at 3.00am to use the toilet and smelled what he described as burning rubber.

99. Another prisoner told the investigator that he had been on C wing for just over a week. His cell was on the third landing immediately above the man's cell which was on the second landing. The prisoner said that he had played pool with the man before but thought that he was shy and timid and did not come out of his cell very often. The prisoner said that at around 11.00pm he had smelled something strange, which he described as burning plastic or wires. He said that he had woken up again at 12.30am and 4.30am and could still smell the same smell.

100. An officer told the investigator that at approximately 1.00am, while undertaking security checks on the wing, she noticed an unusual smell on the third landing, which she described as a chemical smell. The officer then went to fetch another officer. They checked the cleaning cupboard for spilt fluids, and also the wires on the wall phone, but found nothing unusual. They did not check any cells. The officer described the smell as like a burning wick or incense stick, but said that there was no smoke anywhere on the wing.

101. The officer told the investigator that, when he arrived for duty that evening shortly after 7.15pm, he had received a handover from the staff on duty at the time and was told that there were no prisoners on ACCT documents on C Wing. He had then completed a roll check to ensure that every prisoner was

present in their cell and there were no concerns or issues. The officer said that there was only one cell bell pressed, early that night, as the electric supply to a cell on the third landing had tripped.

102. The officer explained that he and the other officer took it in turns to do the hourly prescribed checks which include security patrols around the wings at regular intervals. There are varied routes for the officers to patrol to prevent the checks being predicted by prisoners and an electronic "pegging" system is used which requires night patrol staff to register a device at various points on the wing. Prison records show that the two officers did not undertake the required route for that night and had not patrolled along the second landing, where the man's cell was.

103. On 6 August, at approximately 7.10am, another officer came on duty and had begun to conduct an early morning roll check when she smelled smoke, but could not seen any. She immediately telephoned the orderly officer in charge of the prison who said he would come straight away.

104. The officer continued the roll check and, when she arrived at the man's cell, she looked through the observation panel in the door and saw nothing but smoke. She immediately radioed an emergency and records show that the control room called the fire brigade and ambulance at 7.14am. The orderly officer told the investigator that he arrived within seconds of this call being made but could not see any smoke on the wing. .

105. The officer and orderly officer used a fire hose to spray water into the cell. Cell doors have inundation points, a removable bung that allows a hose to be used to spray water into a cell without opening the door. The orderly officer was unable to remove the inundation point cover so instead he opened the cell door slightly. The door was obstructed but he was able to open it enough to use the hose. An officer had responded to the emergency radio message and he and the orderly officer forced the door open further. The officer went into the cell wearing a fire protection hood and found the man lying immediately behind the cell door.

106. The officer pulled the man out of the cell onto the landing. It was clear from the presence of rigor mortis and severe burns to the man's head that he had been dead for some time and resuscitation would not be possible.

107. A nurse from the prison's healthcare team, arrived for duty at the same time as paramedics arrived at the prison. She went with them to C wing. The nurse told the investigator that she and the paramedics agreed that the man had been dead for some time and covered his body with blankets.

Contact with the man's family

108. The prison's head of residence, acted as the prison's family liaison officer. He went to the man's mother's home at 10.30am to break the news, explain the circumstances of his death and offer support. Wealstun kept in contact with the man's family to provide ongoing support and offered financial assistance towards the funeral expenses in line with national guidance.

Support for staff and prisoners

109. A hot debrief was held at 8.30am for those involved in the emergency to discuss what had happened and to offer support to the staff involved. The services of the prison's care team were made available.

110. Officers and members of the chaplaincy supported prisoners affected by the incident. Prisoners subject to suicide and self-harm monitoring were reviewed in case they had been adversely affected by the man's death.

Investigation by Crown Premises Investigation Group

111. The Crown Premises Inspection Group (CPIG) is the enforcing authority for general fire precautions in government buildings, including all prisons in England and Wales. CPIG carried out an investigation into how the man had set the fire.

112. Wealstun had been subject of a CPIG audit on 27 June 2013. At the time they had noted that two inundation points on B wing had failed to open when tested and that two different keys were being used. As a result of the CPIG fire safety audit in June, plans had already been agreed to refurbish the prison, including fitting smoke detectors in cells. This was due to being in September 2013.

113. The CPIG report refers to the fire investigation report undertaken by West Yorkshire Fire & Rescue Service which determined that the man had most likely set fire to pieces of clothing using a cigarette lighter. The initial fire filled the cell with smoke and then reduced to a slower rate of burning due to a limited supply of fuel and oxygen. It appears that the man was sitting with his back against the wall, between the door and the washbasin, when he was overcome by inhalation of smoke, lost consciousness and slumped over. He came to rest with his head against the door and partially in the fire. The man had removed his bedding and placed it in and over the toilet, and a number of clothing items, polyester jogging pants and jeans had been placed around the foot of the cell door and around the sides and top of the door. This explained the limited spread of smoke past the cell door during the fire. Photographs of the scene, taken by West Yorkshire Police, showed signs of smoke on the cell door frame, indicating that some smoke did pass into the landing during the fire. The CPIG investigators concluded that, from the attempts that the man had made to cover the toilet and seal the cell door to prevent smoke escaping, it is likely that his actions were deliberate and that he intended to conceal the fire.

ISSUES

Assessment of risk of suicide and self-harm

114. The man had a long history of mental illness for which he was prescribed medication. He had previously attempted suicide in the community in 2006. When he first arrived in custody at HMP Leeds, he said he had thoughts of suicide and the staff opened an ACCT. We consider that this was appropriate. However, none of the subsequent ACCT reviews at Leeds were multidisciplinary and the ACCT was closed without any involvement of the mental health team. (We do not make a recommendation to Leeds about this as we have drawn attention to other similar deficiencies in ACCT procedures there in recent investigations into deaths at Leeds.)

115. After the man's transfer to Wealstun, he was managed appropriately under ACCT procedures a number of times. Most of the ACCT reviews were multidisciplinary with good consistent attendance by a member of the healthcare team, usually the nurse who was his mental health key worker at the prison. This was good practice. However, several ACCT reviews did not include healthcare representatives including initial reviews where such attendance is a mandatory requirement under ACCT procedures set out in Prison Service Instruction (PSI) 64/2011. An ACCT was closed on 24 June 2013, the second case review for that ACCT, without any healthcare involvement at either review, despite the man's well documented mental health problems. Case management was also inconsistent. For the ACCT that was open longest (from 11 September 2012 to 23 October 2012), there were four different case managers for eight reviews, and only on one occasion did a manager chair consecutive reviews.

116. We do not consider that the level of the man's risk was always appropriately assessed or that monitoring arrangements appropriately reflected this risk. On 21 September 2012, the man was found with a ligature around his neck apparently after considering hanging himself (he also claimed to have taken an overdose of medication). Yet at an ACCT review the next day, his level of risk of suicide and self-harm was assessed as low. On 28 October 2012, when the man's level of risk was assessed as raised the level of observations was set as one each morning and afternoon and every two hours throughout the night which is not commensurate with a raised level of risk. When an ACCT was opened on 21 June 2013, the level of observations was set during the day at one every morning, afternoon and evening yet his level of risk was assessed as raised. ACCT observations do not always seem to have been clearly recorded on the cover of the document. There are several occasions (such as 7 October 2012) when recorded checks were seemingly made every hour, on the hour, and not at random intervals within that frequency.

117. We are also concerned that an ACCT was not opened on 30 July 2013 when a Listener told the officer that the man had said he intended to take his own life. Although the officer knew the man and went to see him, he had an extensive history of suicide and self-harm. As someone suffering from schizophrenia he was at far greater risk of suicide than others. He had asked to speak to a Listener who was so concerned about this that he had breached the usual confidentiality and asked the officer to sign his note of the interview. An ACCT should have been opened on the basis of this information to provide active

support and help manage and reduce the man's level of risk. We cannot know whether further support would have prevented the man's death but it is likely that if an ACCT had been opened staff would have been required to monitor him on the night he died. We make the following recommendation:

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

- **A multidisciplinary approach for all case reviews;**
- **Assessing the level of risk and recording the reasons for decisions;**
- **Setting appropriate frequency of reviews and levels of observations which are adjusted as the perceived risk changes and which are clearly recorded on the cover of the ACCT document;**
- **Continuity of case management;**
- **Conducting observations at random intervals within the specified frequency.**

Clinical care

118. The clinical review found that the man had appropriate access to healthcare. The same registered mental health nurse saw him very frequently at Wealstun and he had good continuity of care. The transfer from Leeds to Wealstun ensured that the man remained under the care of the same psychiatrist.

119. The review specifically looked at the medication that the man was prescribed, a combination of antipsychotic agents and a mood stabilizer. The mood stabilizer appears to have had a beneficial effect and he took it regularly. Antipsychotic agents were prescribed every two weeks, at the level of 100mg, by depot injection, which is in line with the maximum dosage recommended in the British National Formulary (BNF). When the man's usual antipsychotic was unavailable, the psychiatrist prescribed an alternative which he had used before.

120. The clinical effect of this medication lasts from three to six weeks, but adequate control is often maintained with one injection every four weeks. The reviewers found no obvious link between the regime of the man's depot injection, the frequency of delivery and his behavioural problems, although on two occasions ACCTs were opened on the day that the man was due to receive the injection.

121. The reviewers noted that the man often made allegations and reported issues that had no factual basis. They said that this is not uncommon in patients with similar mental health problems to those of the man and undoubtedly made treatment more challenging in his case.

122. The reviewers made three recommendations about medical records, care plans and mental health assessment tools used at Wealstun. As these issues are not directly related to the man's death we do not repeat the recommendations in this report, but the Head of Healthcare at Wealstun will need to address them.

123. Overall, the review concludes that the man received mental health care comparable to what he could have expected to receive in the community.

Bullying

124. The man made several allegations that he was being bullied or teased. These included allegations on 24 April 2012, 15 April 2013 and 30 June 2013, although there were also several other examples. We have seen evidence that these allegations were investigated. However, on each occasion, when the man was interviewed, he retracted or played down his original comments, including when he had made allegations of sexual abuse when he said he had been asked to do something which he had refused. No further action was taken and, in relation to these serious allegations, the man signed a disclaimer to say that he did not want to refer them to the police for investigation.

125. It has not been possible to establish whether the man was being bullied or not and we note the comments of the clinical reviewers that making allegations not based on fact is not uncommon in patients with his mental health problems. However, the number of incidents and allegations suggests that, at the very least, some further action should have been taken to assess whether the man was being bullied. We have not seen any evidence that his previous allegations were considered in safer prisons reports into individual investigations or that his circumstances were looked at in the round. As a result, no overall assessment was made of whether the man was being bullied frequently, or if he needed some further intervention to support him. We make the following recommendation:

The Governor should ensure that safer custody officers consider previous allegations of bullying when assessing whether a prisoner is at risk, and put appropriate preventative measures in place where necessary.

Possession of a cigarette lighter

126. The man's family were concerned about his access to materials to cause a fire and whether he should have been monitored more carefully because of his offence. The only restrictions on the provision of lighters or matches for prisoners would be when there was specific intelligence that a prisoner was liable to set a fire or was at risk of using them to harm himself. Despite the circumstances of the man's offence, he had not set any cell fires before and there was no specific intelligence to suggest that he was going to do so which would have justified removing a cigarette lighter of matches from him. At the time of his death, he was not being monitored as a risk of suicide or self-harm but, if he had been, it is unlikely that a lighter or matches would have been removed from him. At Leeds in March 2012, staff had removed razors from his cell when he had cut his arms, but there was no evidence of him previously using fire to self-harm. In any event a prisoner told the investigator that he had given the man some tobacco and a cigarette lighter on the night of his death. Even if officers at Wealstun had removed all such objects from the man, he would still have had access to them.

Actions of staff on the night of 5 and 6 August

127. There is evidence from the accounts of both prisoners and the officers on duty that there was an unusual smell on C wing on the night of 5/ 6 August. We consider that the two officers should have alerted the night orderly officer about

this issue and should have done more, including checking each cell, to establish the cause of the smell and satisfy themselves that there was no emergency. We do not know whether this would have prevented the man's death as we do not know exactly when or how quickly it occurred, but we do not consider that the risk was appropriately investigated. The investigation has identified that the two members of staff on duty carried out checks that night but the pegging system was not fully functional. The checks they made did not include the man's landing, as would have been expected. This further reduced the opportunity to identify the source of the smell, which was the fire the man had lit in his cell. We make the following recommendations.

The Governor should ensure that staff on duty at night conduct security checks in line with local instructions.

The Governor should ensure that staff conduct thorough checks to ensure the safety of prisoners when they are alerted to a potential emergency at night.

Emergency response

128. Staff responded swiftly when smoke was found in the man's cell. When the man was moved out of the cell it was clear that he had been dead for some time as rigor mortis was evident. The European Resuscitation Council Guidelines for Resuscitation 2010 state that "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile …". We are satisfied that the decision not to attempt resuscitation was appropriate.

129. While we acknowledge the action the staff took, we are concerned they were unable to open the inundation point in the man's cell despite the fact that the inundation points on the wing were working correctly. CPIG had found that not all inundation points they checked on other wings were functional. We make the following recommendation:

The Governor should hold regular fire training for staff, including the correct method of using inundation points which should be checked regularly to ensure they are functional.

RECOMMENDATIONS

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

    - A multidisciplinary approach for all case reviews;
    - Assessing the level of risk and recording the reasons for decisions;
    - Setting appropriate frequency of reviews and levels of observations which are adjusted as the perceived risk changes and which are clearly recorded on the cover of the ACCT document;
    - Continuity of case management;
    - Conducting observations at random intervals within the specified frequency.

2. The Governor should ensure that staff on night duty conduct the mandatory security checks, as detailed in the local instructions.

3. The Governor should ensure that safer custody officers consider previous allegations of bullying when assessing whether a prisoner is at risk, and put appropriate preventative measures in place where necessary.

4. The Governor should ensure that staff on duty at night conduct security checks in line with local instructions.

5. The Governor should ensure that staff conduct thorough checks to ensure the safety of prisoners when they are alerted to a potential emergency at night.

6. The Governor should hold regular fire training for staff, including the correct method of using inundation points which should be checked regularly to ensure they are functional.

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 prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including: •A multidisciplinary approach for all case reviews; •Assessing the level of risk and recording the reasons for decisions; •Setting appropriate frequency of reviews and levels of observations which are adjusted as the perceived risk changes and which are clearly recorded on the cover of the ACCT document; •Continuity of case management; •Conducting observations at random intervals within the specified frequency.	Accepted.	Guidelines for the Management of prisoners at Risk of Harm to self, to others, and from others Safer Custody (PSI 64/2011) will be reissued to all staff within HMP Wealstun Local safer custody training will include learning from deaths and incidents both at Wealstun and other establishments through local investigation report conclusions, regional safer custody minutes, national quick time learning bulletins, and other publications from headquarters. Case Managers will assess each ACCT review to ensure it involves staff from appropriate disciplines, and includes staff that have regular interaction with the prisoners such as Healthcare, Activity Staff, Mental Health Professionals, and Chaplaincy members etc. ACCT Case Managers will ensure there are dynamic reviews of individuals' risk, plus targeted reviews if risk is increased or circumstances change, and that these reviews are recorded including the reasons for the decisions. Management checks will include scrutiny of where risks have been identified as heightened, observation levels have been increased, and where risks are identified as being lower, observation levels have been	31/12/2014 Head of Residence and Safety and Safer Custody Department	

Action Plan					
No	**Recommendation**	**Accepted/Not Accepted**	**Response**	**Target date for completion and function responsible**	**Progress (to be updated after 6 months)**
			reduced. That the frequency of reviews is both appropriate and recorded clearly on the front cover, and that observations are at random intervals within the specified frequency. Safer Custody Managers will promote continuity of case manager arrangements.		
2	The Governor should ensure that staff on night duty conduct the mandatory security checks, as detailed in the local instructions.	Accepted	Local Night Operating Instructions will be re-published. Duty Governors undertaking Night Visits will test staff understanding and compliance of these instructions.	31/12/2014 Security	
3	The Governor should ensure that safer custody officers consider previous allegations of bullying when assessing whether a prisoner is at risk, and put appropriate preventative measures in place where necessary.	Accepted	Safer Custody Managers will complete a Management Check of all completed Safer Prisons investigations to ensure previous allegations of bullying have been considered in the resolution of the allegation. Where it is identified that a prisoner is at risk he will be safeguarded by a change of location and the information on the prisoner at risk will be shared with other staff in relevant areas of the establishment. A Safer Custody Investigation will be conducted into the alleged perpetrator(s) and if proved pro-active action taken to reinforce the prisons zero tolerance approach to violence and anti social behaviour.	31/12/2014 Safer Custody	

Action Plan					
No	**Recommendation**	**Accepted/Not Accepted**	**Response**	**Target date for completion and function responsible**	**Progress (to be updated after 6 months)**
4	The Governor should ensure that staff on duty at night conduct security checks in line with local instructions.	Accepted	Local Night Operating Instructions will be re-published. Duty Governors undertaking Night Visits will test staff's understanding and compliance of these instructions.	31/12/2014 Security	
5	The Governor should ensure that staff conduct thorough checks to ensure the safety of prisoners when they are alerted to a potential emergency at night.	Accepted	A specific Local Security Instruction will be created to ensure that staff carry out checks on the safety of prisoners when they are alerted to a potential emergency at night.	31/12/2014 Security	
6	The Governor should hold regular fire training for staff, including the correct method of using inundation points which should be checked regularly to ensure they are functional.		Every wing's inundation points are all checked quarterly by staff on rotation so that all staff become familiar with the technique. The works department checks the operation of inundation points twice yearly. Respiratory Protective Equipment (RPE) training is undertaken by all uniformed staff yearly which includes the operation of inundation points and entering a cell in the event of a fire. Evacuation drills are carried out yearly in all areas. In cell fire detection is currently being installed in all cells throughout the establishment.	In place September 2015 Major contract being carried out by external contractors	Complete