Prisons & Probation Ombudsman
Independent Investigations

Investigation into the death of a prisoner at HMP Bristol on 10 January 2015

A report by the Prisons and Probation Ombudsman
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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

The man was found hanged in his cell at HMP Bristol on 10 January 2015. He was 41 years old. I offer my condolences to the man's family and friends.

The man had tried to kill himself two days before he was remanded to Bristol. When he arrived, staff identified he was at risk of suicide and self-harm, but I am concerned that the extent of his risk was not recognised and staff did not monitor him sufficiently frequently. Despite the man's very recent serious suicide attempt, he did not have an urgent mental health assessment. The prison did not follow mandatory national procedures for managing prisoners at risk of suicide and self-harm. On the morning he died, he had not been checked as he should have been, and it is unacceptable that staff initially attempted to conceal this.

This version of my report, published on my website, has been amended to remove the names of the man who died and staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **October 2015**

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Summary

Events

1. On 8 January 2015, the man arrived at HMP Bristol, charged with possessing and making indecent photographs. He had tried to kill himself two days earlier, and court staff completed a suicide and self-harm warning form. Prison reception staff began Prison Service suicide and self-harm prevention procedures (known as ACCT), when he arrived. The man was prescribed medication for alcohol detoxification and accommodated on the drug and alcohol stabilisation unit. Because of the nature of his offence, he was kept separate from the other prisoners in the unit.

2. Before he arrived at Bristol, the court advice and referral service contacted the prison because they were concerned about the man's mental health. The mental health team scheduled a mental health assessment for 20 January.

3. A supervising officer assessed the man as at raised risk of suicide or self-harm and instructed staff to check him at least hourly. During the evening of 9 January, the man was not checked for three hours, from 5.30pm until 8.30pm. He was checked hourly overnight. A healthcare assistant last checked the man at 7.30am (although an officer later falsely added that he checked him at 8.15am). No one checked him again until an officer looked into the man's cell at 9.13am, and saw he had hanged himself. Resuscitation efforts were unsuccessful and, at 9.55am, paramedics pronounced the man dead.

Findings

4. The man had seriously attempted suicide two days before he arrived at the prison. He was withdrawing from a dependency on alcohol and had been remanded for serious offences. Although he was identified as at risk of suicide and self-harm, we do not consider that the level of risk or observations reflected the man's actual risk. A supervising officer held the man's only ACCT case review on his own, without consultation with colleagues or healthcare staff. There was confusion about responsibility for ACCT checks and staff did not carry out checks at the required frequency. One officer falsely wrote that he had checked the man on the morning that he died.

5. Despite the man's serious attempted suicide, two days before he arrived at the prison, the mental health team did not assess him urgently. He had no mental health assessment before he died.

Recommendations

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

- Holding multidisciplinary case reviews which include all relevant people involved in a prisoner's care;
- Considering all known risk factors when determining the level of risk of self-harm;
- Setting appropriate levels of observations to reflect identified risk;

- Checking prisoners at risk, as directed; and
- Setting clear responsibilities for undertaking ACCT observations, which managers check to ensure they happen.

The Governor and Head of Healthcare should ensure that the prisoners who have recently attempted suicide have an urgent mental health assessment.

The Investigation Process

6. The investigator issued notices to staff and prisoners at HMP Bristol informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

7. The investigator visited the prison on 16 January 2015 and obtained copies of relevant extracts from the man's prison and medical records.

8. NHS England commissioned a doctor to review the man's clinical care at the prison. The investigator and clinical reviewer interviewed 12 members of staff, some jointly. At the initial report stage, the National Offender Management Service (NOMS) responded to the recommendations. That response is included below the recommendations at the end of this report.

9. We informed HM Coroner for Avon of the investigation who gave us the results of the post–mortem examination. We have sent the coroner a copy of this report.

10. One of the Ombudsman's family liaison officers contacted the man's father to explain the investigation and to ask if he had any matters he wanted the investigation to consider. The man's father said that when his son's belongings were returned his boots still had laces in them. The man's father understood he had used laces to hang himself and asked why he would be allowed to have laces, if he was at risk of suicide or self-harm. The man's father 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.

Background Information

HMP Bristol

11. HMP Bristol is a local prison, which can hold about 600 sentenced and remanded men. Bristol Community Health and Medco Secure Health Services provide primary healthcare and substance misuse services. Avon and Wiltshire partnership provide mental health services. All wings have a treatment room staffed by a nurse and healthcare assistants during the day. There is a nurse and a healthcare assistant on duty to cover the prison throughout the night.

12. At least one GP is on duty during the week from 7.00am to 8.30pm, and on Saturday afternoon and Sunday morning. An out of hours service is used at other times. There are no inpatient beds.

HM Inspectorate of Prisons

13. The last inspection of HMP Bristol was in October 2014. Inspectors found that suicide and self-harm prevention procedures were weak, although prisoners said they felt well supported by the process. The quality of entries was variable and case reviews were not multidisciplinary. Reception and first night procedures had improved since the previous inspection in May 2013, as had services for prisoners with drug and alcohol problems. Inspectors described the living environment on C Wing as very poor, especially on the drug stabilisation unit.

Independent Monitoring Board

14. 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 recently published report for the year to July 2014, the IMB described the substance misuse service as effective and well established. They were concerned that the number of officers on C Wing had sometimes fallen to a level that meant healthcare staff were advised not to unlock prisoners.

Previous deaths at HMP Bristol

15. The last self-inflicted death at Bristol was in 2013. In the investigation report into that death, we recommended that ACCT reviews should be multidisciplinary. In this investigation, we found that a supervising officer held an ACCT case review on his own.

Assessment, Care in Custody and Teamwork

16. ACCT is the care-planning system the Prison Service used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.

17. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner. As part of the

process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

18. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

19. On 31 July 2013, the man was arrested for possessing and making indecent photographs. On 8 December 2014, the man was charged and released on bail. The man was due to appear at court on 8 January 2015.

20. On the night of 6 January 2015, the man tried to kill himself by connecting a hosepipe from a car exhaust to the interior of the car. He drank a bottle of wine and a bottle of whiskey, and overdosed on medication. Work colleagues discovered him the next morning and he was taken to hospital. He left hospital before staff could assess his mental health. Hospital staff informed the police, who found and arrested the man as they were concerned he would not appear at court the next day. He was held in police custody and a doctor prescribed diazepam for symptoms of alcohol withdrawal. A mental health nurse assessed that the man was at high risk of suicide and self-harm.

21. The man arrived at court at around 9.00am on 8 January. Police custody staff completed the man's Person Escort Record (PER), a document that goes with prisoners when they move between police stations, courts and prisons. They wrote that he suffered from depression and had attempted suicide by car exhaust inhalation and overdose the previous day. At around 9.30am, a senior custody officer from GEO Amey Escort Services completed a suicide and self-harm warning form.

22. The court advice and referral service spoke to a prison mental health nurse that day. They said the man needed a mental health assessment, because of his alcohol use and his risk of suicide and self-harm. The mental health nurse arranged a mental health assessment for 20 January, before his next scheduled court appearance.

23. The court remanded the man into custody and he arrived at HMP Bristol at around 4.35pm. He had been in prison before. Reception staff gave him a pair of prison shoes and his own boots were stored with his other belongings.

24. Officer A started suicide and self-harm prevention (ACCT) procedures in reception and Supervising Officer (SO) A completed an ACCT immediate action plan. He instructed staff to check the man once an hour until he had been properly assessed. SO A recorded that the man had been offered access to Listeners (prisoners trained by the Samaritans to support other prisoners in distress) and a telephone call to his family and the Samaritans.

25. Nurse A recorded in the man's medical record that he had a very sore throat due to his suicide attempt. He told her he usually drank more than nine units of alcohol a day. She noted that ACCT procedures had been started because of the man's recent suicide attempt. The nurse did not refer the man to the GP or for an urgent mental health assessment.

26. The man was regarded as vulnerable to threats and attack from other prisoners, because of the nature of his alleged offences. However, he was withdrawing from alcohol and needed to be monitored by healthcare staff, which meant he could not immediately go to the vulnerable prisoners' wing. SO A decided to locate the man on the third landing of C Wing, which is the stabilisation unit, but keep him separate

from other prisoners. On a wall chart in the wing office, the man was marked as a vulnerable prisoner, but there was no indication that he was subject to ACCT monitoring. His ACCT document was kept in the wing office.

27. Nurse B was the duty nurse on C Wing on the evening the man arrived. She made no entries in the man's medical record or in his ACCT record. Although the man had taken diazepam in police custody, Nurse B did not give him any medication that evening. Healthcare staff checked the man at least hourly overnight.

28. At 8.30am on 9 January, Nurse C completed a segregation health screen because the man was being held separately from other prisoners in the stabilisation unit. She recorded that the man was subject to ACCT monitoring, but she did not consider that his mental health would deteriorate significantly if segregated. She concluded that the man could cope with being segregated in the stabilisation unit. However, there is no record that the man was formally segregated and the duty governor did not sign the authorisation.

29. A member of healthcare staff checked the man for symptoms of alcohol withdrawal twice a day. Healthcare assistant D saw the man at about 10.30am, but did not write in his ACCT record. She took his clinical observations, which were normal, and noted that he was not eating or drinking much.

30. At around 10.40am, Ms A, a recovery support worker from the substance misuse team, assessed the man's substance misuse needs and offered him support. Ms A recorded that the man appeared hopeless and low in mood but he did not express any thoughts of suicide or self-harm. He told Ms A he had been diagnosed with a narcissistic personality disorder, and his previous experience of mental health services had not been positive. He said he needed alcohol to function, and did not want help to stop drinking alcohol. Ms A did not write anything in the man's ACCT record.

31. At around 11.00am on 9 January, Ms B, an operational support grade, assessed the man as part of the ACCT process. The man said he could not see a future because of his charges and he wished his suicide attempt had been successful. The man did not want any contact with his family or girlfriend, as he thought they were better off without him. He avoided saying whether he had any thoughts of suicide or self-harm, but said it did not matter if he was dead or alive. The man asked Ms B for antidepressants, and said he would be happy to see someone from the mental health team. Ms B concluded that the man's ACCT monitoring should continue until a mental health specialist assessed him, which she noted had been scheduled for 20 January.

32. Dr A saw the man at around midday on 9 January. The man said that he had no concerns about his physical health, but he had tried to kill himself two days before, and was only regretful that he had not managed it. She noted the man was being monitored under ACCT procedures, although she did not write anything in the ACCT document. Dr A prescribed chlordiazepoxide to treat symptoms of alcohol withdrawal. She noted that the man would like mental health support, but this was to start after his detoxification.

33. At 4.00pm, SO C held an ACCT case review with the man in his cell. SO C recorded that Ms B and Officer B were at the review. In fact, he referred only to Ms

B's written assessment but did not speak to her, and he spoke to Officer B after the review. He did not arrange for a member of healthcare staff to contribute to the review, which is a mandatory requirement for the first ACCT case review.

34. SO C said the man was on the top bunk and had a towel over his head during the case review. He said that the man said that he had tried to kill himself because he was depressed. The man told him that his medication was not controlling the symptoms of his alcohol withdrawal. SO C assessed the man's risk of suicide or self-harm as raised (on a scale of low, raised or high) and set his level of observations as hourly. He said that he reached this decision because the man had engaged with the review, did not consider himself at high risk of suicide and had not harmed himself in the short time he had been at the prison. SO C scheduled another case review for two days later, when he hoped the man's physical symptoms of alcohol withdrawal would have stabilised. SO C recorded two issues in the man's caremap: depression/attempted suicide and alcohol withdrawal. He noted that the man had a mental health appointment on 20 January, and his substance misuse treatment was ongoing.

35. At 4.30pm, Officer B recorded that the man was unlocked to collect his medication. Ms Carol Matthew, a healthcare assistant, saw the man for a secondary health screen, and he told her that he did not feel like harming himself. She did not write in the man's ACCT document. Officer B and Officer C checked the man hourly throughout the day.

36. At 5.30pm, Officer B recorded in the ACCT on-going record that the man was sitting on his bed. Officer B said that he left the landing at around 6.00pm and went to another landing. Mr C, a healthcare assistant, wrote the next entry in the man's ACCT record three hours later, at 8.30pm. Mr C recorded that the man was watching his television and continued to record observations at least hourly throughout the night.

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37. Mr D, the custodial manager who was in charge of the operation of the prison that night, visited C Wing at 1.00am. Mr D checked the man's ACCT record during his visit but did not notice the missing observations. Mr E, a night patrol officer, did a morning roll check at 5.10am.

38. Ms F, a healthcare assistant, arrived on the landing at around 7.00am. Ms F said Mr C did not hand over any concerns about the prisoners on the landing. At around 7.30am, Ms F noticed the man's ACCT document in the staff office, and saw that he was due to be checked, so went to his cell. Ms F recorded that the man was asleep and breathing at the time. This was the last time a member of staff checked the man.

39. Officer B recorded in the ACCT record that he had checked the man at 8.15am and that he was asleep. He later admitted that he had not checked the man, and said SO F asked him to write this entry. Officer B and SO F have been subject to a disciplinary investigation.

40. At around 9.13am, Officer Christopher E looked through the open observation hatch in the man's cell as he was about to unlock his door. He noticed a towel over

the end of the top bunk and could see that the man was hanging underneath it. Officer E radioed a code blue emergency call and the control room called an ambulance. (An emergency code blue indicates a prisoner is unconscious, not breathing or is having breathing difficulties.) Officer E went into the cell, cut the shoelaces around the man's neck and laid him on the floor.

41. Nurse E, Mr G, healthcare assistant, and Ms G arrived within a minute of the code blue call. Nurse E said the man was cold, had no pulse and his lips were beginning to go blue. Officer E and Nurse E started cardiopulmonary resuscitation. Ms G attached the defibrillator (a life saving device that gives the heart an electric shock to restart the heart rhythm in some cases of cardiac arrest). The defibrillator found no shockable rhythm and the staff continued resuscitation.

42. The ambulance arrived at the prison gates at 9.21am. The paramedics reached the man's cell at 9.26am, and took over emergency treatment. At 9.55am, the paramedics pronounced that the man had died.

Contact with the family

43. At 1.30pm, Officer F and the Governor told the man's father that he had died. They offered condolences and support. The prison contributed to the funeral, in line with national guidance

Support for prisoners and staff

44. After the man's death, the Governor debriefed the staff involved in the emergency response and the prison's care team offered support. She issued notices to staff and prisoners informing them of the man's death. Officers and members of the chaplaincy team supported prisoners. Staff reviewed all prisoners who had been assessed as at risk of suicide and self-harm, in case they had been adversely affected by the man's death.

Post-mortem report

45. A post-mortem examination recorded the man's cause of death as pressure to the neck. Toxicology tests found no trace of alcohol or any commonly misused drugs in the man's bloodstream.

Findings

Management of the ACCT process

46. The man was appropriately identified as at risk of suicide or self-harm in reception, and staff monitored him until he died less than two days later.

ACCT case review

47. Prison Service Instruction (PSI) 64/2011, which governs safer custody, requires a member of healthcare staff to attend the first ACCT case review and the ACCT assessor, where possible. The PSI says that a member of staff who knows the prisoner, such as a wing officer, the person who raised the initial concern and any other member of staff who has, or will have contact with, the prisoner at risk or who can contribute to their support and care. Other ACCT case reviews should be multidisciplinary where possible.

48. SO C conducted the man's only case review in his cell, without any other member of staff present, contrary to the instruction. He said that he read the ACCT assessment, but did not speak to the assessor, and did not invite a member of the healthcare team, or any other officer to the review. SO C identified the man's substance misuse and mental health as the two issues to be addressed in his caremap, yet there is no record he discussed them with a healthcare professional.

49. The man's only case review did not meet the requirements of the PSI, and we do not think that it adequately considered the man's risk.

Assessment of risk

50. PSI 64/2011 also requires that:

> *"Staff must follow the level of observations and conversations as stated in the 'required frequency of conversation and observations box' on the front cover of the ACCT. These must be recorded immediately or as soon as practicable thereafter."*

51. SO C considered the man was at raised risk of suicide or self-harm, rather than high risk. He said he took into consideration that the man had not self-harmed in prison, that he did not consider himself at high risk of suicide or self-harm and that he had spoken quite openly during the case review. He instructed staff to continue checking the man hourly.

52. We are concerned that the supervising officer conducted an ACCT review alone. The man had made a very serious attempt to kill himself just two days earlier. A mental health nurse, when he was in police custody, had assessed him as at high risk of suicide. He had told the ACCT assessor that he wished his suicide attempt had been successful, and that he had no future. Just hours before the review, he had told a doctor that it did not matter if he was dead or alive. We consider that SO C's assessment of the man's risk as raised did not reflect the seriousness of his attempted suicide, and he should have been considered as high risk, with more frequent observations.

ACCT observations

53. Staff were instructed to check the man at least hourly for the brief time he was in the prison. No ACCT checks were carried out on the man from 5.30pm until 8.30pm on 9 January. The night manager did not notice the missing observations. The investigator found some confusion about whether healthcare staff or officers in the stabilisation unit considered themselves responsible for completing ACCT observations. There was further confusion, as the man was not marked as being subject to ACCT monitoring on the wall chart in the staff office (although his ACCT document was in the wing office).

54. After the man's death, on 2 February 2015, the Governor issued a local notice (LNTS 18/2015) informing staff that all ACCT observations must be carried out and recorded by officers. ACCT records are allocated to individual officers each day to ensure that the prisoner is monitored throughout the day.

55. A number of healthcare staff saw the man in his short time at the prison, and talked about his suicide attempt, willingness to engage with mental health treatment, and his substance misuse. However, no healthcare professionals wrote in his ACCT record. In the local notice, the Governor also reminded healthcare staff that they must record relevant information about a prisoner's risk in the ACCT record.

56. On the morning that the man died, no one checked him after 7.30am. Although Officer B wrote that he had checked him at 8.15am, he later admitted that he had falsely added this entry because SO F had persuaded him to. Both officers have been subject to a disciplinary action so we make no further recommendation about this. It is a serious concern that there was a gap in observations on the morning of 10 January, during which time the man hanged himself. It is possible that a check at the required time, might have prevented the man's actions.

57. Officers did not check the man in line with his perceived level of risk, and we do not consider that the prison effectively monitored his risk of suicide or self-harm. We therefore make the following recommendation:

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

    - **Holding multidisciplinary case reviews which include all relevant people involved in a prisoner's care;**
    - **Considering all known risk factors when determining the level of risk of self-harm;**
    - **Setting appropriate levels of observations to reflect identified risk;**
    - **Checking prisoners at risk, as directed; and**
    - **Setting clear responsibilities for undertaking ACCT observations, which managers check to ensure they happen.**

Removal of items from prisoners at risk of suicide and self-harm

58. The man's father was concerned that he had laces from his prison shoes in his cell, which he used to kill himself. PSI 64/2011 instructs that staff should:

> *"Consider and agree whether any items which the prisoner might use to self-harm should be removed from them. Removal of items should be kept to a minimum and must never be automatic."*

59. When interviewed, the Safer Custody Manager said that staff would not routinely remove items, including laces, from a prisoner because it is not decent to remove their personal possessions. We agree that staff should not usually remove a prisoner's personal possessions, as this can lower their self-esteem and increase their risk. As the man had not been identified as at high risk of suicide and self-harm, it is unlikely that they would have decided to remove any items. However, as noted above, we consider that staff underestimated his level of risk and did not hold an appropriate ACCT case review. If the man's risk had been assessed as high, it is possible he would have been held in a safer cell with fewer ligature points and he would have been monitored more frequently.

Mental health assessment

60. The mental health team made an appointment to assess the man on 20 January. The man had tried to kill himself two days before he went to prison and left hospital before his mental health was assessed. He told the ACCT assessor and a doctor that he was disappointed not to have succeeded, and that he had no future. The court advice and referral service contacted the prison before he arrived there, to request that they review his mental health in light of his serious suicide attempt and excessive alcohol use. In the circumstances, we are surprised that the man was not referred for an urgent mental health assessment. We therefore make the following recommendation:

> **The Governor and Head of Healthcare should ensure that the prisoners who have recently attempted suicide have an urgent mental health assessment.**

Clinical care

61. The clinical reviewer concluded that overall the clinical care the man received at Bristol was comparable to that he could have received as a patient in the community. He identified some areas for improvement in the delivery of healthcare services, which the Head of Healthcare will need to address.

Action plan

No	Recommendation	Accepted / Not accepted	Response	Target date for completion and Function Responsible
1	The Governor and Head of Healthcare should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including: Holding multidisciplinary case reviews which include all relevant people involved in a prisoner's care; Considering all known risk factors when determining the level of risk of self-harm; Setting appropriate levels of observations to reflect identified risk; Checking prisoners at risk, as directed; and Setting clear responsibilities for undertaking ACCT observations, which managers check to ensure they happen.	Accepted	A local notice to staff was issued in August 2015 to remind staff the need to ensure multi-disciplinary attendance at ACCT Case Reviews, and ensuring all staff involved in a prisoners care are invited. Staff have been reminded that all known risk factors are considered when determining the level of risk of self-harm and appropriate levels of observations and conversations are set to reflect the identified risk. Staff are aware that entries must be made in the ACCT document as soon as possible. To aid this, staff have been provided with a note book to ensure live time recording of observations and conversations, in the event that they are unable to update the ACCT document. This information is transferred into the ACCT at the earliest opportunity. In the event of an incident of self-harm / suicide, staff notebooks may be requested as evidence to support the ACCT document. The Governor introduced weekend quality assurance ACCT checks on 27th June 2015. These are undertaken by the Duty Governor and consider whether multidisciplinary reviews took place and both observations and conversations were undertaken as required by the ACCT. The findings are shared with Safer Custody and Case Managers who will address any concerns with members of staff. The Regional Safer Custody lead visits the prison on a monthly basis to conduct assurance checks. The suggested actions following the death of The man will be tested as part of this assurance process.	Head of Safety & Equalities - completed
2	The Governor and Head of Healthcare should ensure that the prisoners who have recently attempted suicide have an urgent mental health assessment.	Accepted	Mental Health referrals happen in a number of ways: - Contact from the Court Assessment Referral Service (CARS)(part of the same Criminal Justice team as the Mental Health Team on site) prior to a prisoner arriving in custody. They send a transfer form to the prison marking it for the attention of the Mental	Clinical Services Manager (Bristol Community Health) - completed Team Manager Mental Health (Avon and Wiltshire Partnership Trust) - completed

		Health Team/Worker. This form is sent together with other prisoner's information for handover to reception at the prison - Identification on reception – immediate referral by Bristol Community Health Registered Nurse to Mental Health Team - Information from other sources including the Prisoner Escort Record handed over by escorting staff. There is a Duty Mental Health worker on site from 07.00 to 20.00 hours, 7 days a week. The duty worker will triage all referrals, including those from CARS, to decide whether a further referral to mental health services is needed and whether that referral needs to be done urgently. However, newly received prisoners who have recently attempted suicide will be referred for an urgent mental health assessment.	