



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man,
a prisoner at HMP Highpoint, in May 2014**

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'*

This is the investigation report into the death of a man, who died in hospital in May 2014 after prison staff found him hanging in his cell at HMP Highpoint the previous night. He was 38 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received in prison was undertaken. Staff at HMP Highpoint and HMP Chelmsford co-operated fully with the investigation. The investigation was suspended until toxicology examinations were concluded and I regret the consequent delay in issuing this report.

The man had spent some time on remand at HMP Thameside before moving to Chelmsford in April. He had been in prison before and had previously self-harmed, but said that this was when his drug withdrawal had not gone smoothly. He considered he was now doing well on a methadone detoxification programme. Staff took particular account of a warning form from the court indicating the man might harm himself if he went to Chelmsford. He said that he had not meant this, but was worried that there were other prisoners at Chelmsford who had a grudge against him. The prison took action to protect him but decided he was not at risk of suicide and self-harm. On balance, I am satisfied that the staff at Chelmsford appropriately considered the man's risk factors before reaching this decision.

The man transferred to Highpoint on 23 May. A reception nurse concluded he was not at risk of suicide and self-harm, but an officer did not assess his risk of suicide and self-harm later, as the local policy requires. Instead, another prisoner was responsible for first night procedures, including cell allocation. The man shared a cell with another prisoner who had also come from Chelmsford that day. Later in the evening, he asked what would happen if he swallowed a razor blade and several times asked to move to a single cell. He asked to speak to a peer support worker, but none were available. Some hours later staff gave him a phone to ring the Samaritans, but he could not use this in private. No one considered whether his actions indicated an increase in his risk. It was not until about 11.30pm, when the man said that he had actually swallowed a razor blade that staff decided to begin suicide and self-harm prevention procedures. Shortly afterwards, his cellmate alerted staff that he had hanged himself in his cell. His cellmate said that the man had been asleep during the short time this happened, although another prisoner claimed he later told him otherwise.

It has not been possible to discover for certain the reasons for the man's behaviour at Highpoint that night. We do not know what led him to tie a ligature around his neck and whether he intended to kill himself. However, I am concerned that first night procedures at Highpoint were inadequate and staff should have reacted more effectively to protect him. There were also deficiencies with the emergency response and contact with his family was not as timely or effective as it should have been.

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.

CONTENTS

Summary

The investigation process

HMP Highpoint and HMP Chelmsford

Key events

Issues

Recommendations

SUMMARY

1. The man was remanded to HMP Thameside on 5 March 2014. He had been to prison a number of times before and had been managed under Prison Service suicide and self-harm prevention procedures (known as ACCT) for short periods in the past. He had reportedly tried to kill himself during a previous prison sentence. He used illicit drugs in the community and began a methadone detoxification programme at Thameside.
2. The man appeared in court on 8 April and was remanded to HMP Chelmsford until he was sentenced. He had told his solicitor that he would “top himself” if he was sent to Chelmsford, so court custody staff completed a suicide and self-harm warning form. When he arrived at Chelmsford, he said he did not want to be at the prison because he was afraid of some prisoners there who he believed blamed him for their imprisonment. However, he said that he had not meant what he had said at court and he had no thoughts of suicide or self-harm. Reception staff did not begin ACCT procedures.
3. On 14 May, the man was sentenced to three and a half years in prison. He moved to HMP Highpoint on 23 May. A nurse in reception did not consider the man was at risk of suicide or self-harm but an officer did not assess him as part of the first night process, as the local policy requires. Instead, another prisoner carried out first night procedures, including allocating cells. At around 8.00pm, the man asked to speak to a Listener (a prisoner trained by the Samaritans to support other prisoners in distress) but none was available. There was a two-hour delay before the man was able to use the Samaritans’ telephone as the one assigned to the induction unit was missing. No one considered whether this suggested he was feeling vulnerable or whether they should open an ACCT.
4. Throughout the evening the man made several requests to move to a single cell and suggested he might cut himself. No one asked him why he wanted to move. Later in the evening, he and his cellmate asked an officer what would happen if he swallowed a razor blade. The officer took no action and he and other officers involved told us that they thought the man and his cellmate were testing the boundaries in their new prison. Security intelligence submitted after his death suggested that the man might have taken drugs in the hours before his death, but toxicology tests found no evidence that he had used drugs.
5. At around 11.30pm, the man told the night patrol officer that he had swallowed a razor blade. Officers advised the patrol officer to open an ACCT but no one sought any medical advice. At around 11.55pm, the man’s cellmate told the night patrol officer that he had fallen asleep for a short time and when he woke up he had found the man hanging from a torn sheet attached to the bed frame. (Security information submitted after his death suggests that the cellmate told another prisoner that he was not asleep at the time.) The night patrol officer asked the cellmate to cut the ligature and, rather than using his radio, he went to wing office and telephoned for help. He did not use an emergency code. The man was taken to hospital and put

on life support. No one informed his family until 6.30am. He died shortly afterwards, after life support was withdrawn.

6. The investigation found that first night procedures at Highpoint were not in line with the local policy. During his first evening on the induction wing staff did not fully consider whether the man's behaviour indicated he was at risk and support arrangements were poor. Although it would have been difficult to predict his actions that night, we consider that ACCT procedures should have been opened earlier on the evening of his death. Prison staff did not follow emergency response procedures in line with local and national instructions and no one informed his family of his hospital admission until shortly before his death. We make eight recommendations.

THE INVESTIGATION PROCESS

7. The investigator issued notices to staff and prisoners at HMP Highpoint and HMP Chelmsford informing them of the investigation and inviting anyone who had relevant information to contact him. One prisoner at Chelmsford responded.
8. The investigator visited Highpoint on 30 May 2014 and interviewed the man's cellmate. He met the deputy governor, the prison's family liaison officer and a representative of the local Independent Monitoring Board. He obtained copies of relevant prison and medical records.
9. In July, the investigator interviewed eight members of staff at Highpoint and five members of staff a prisoner at Chelmsford. He informed the Governor of Highpoint of the preliminary findings of the investigation.
10. NHS England commissioned a clinical reviewer to review the man's clinical care in prison.
11. We informed HM Coroner for Greater Suffolk of the investigation, who sent us the post-mortem examination and toxicology reports. Our investigation was suspended until 1 December while toxicology tests were concluded, as there was intelligence that the man had taken drugs shortly before his death. We have sent the Coroner a copy of this report.
12. The investigator and one of the Ombudsman's family liaison officers visited the man's mother and other family members on 2 July. They had the following concerns that they wanted the investigation to consider:
 - The man had been worried for his safety from some other prisoners from Chelmsford and his family were concerned that his cellmate at Highpoint had also been a prisoner at Chelmsford. They thought that he might have acted as he did on the night of 23 May to be moved out of the cell, rather than because he wanted to end his life. They said that he had sent them letters before his death suggesting that he was planning for the future.
 - They had received different accounts of what had happened on the night that he was found hanging, and some of the information was incorrect.
 - They believed that the night patrol officer who opened the ACCT document should have stayed with him and monitored him until support arrived.
 - They were concerned that it took the ambulance an hour to leave the prison and wanted to know whether this delay was because of prison procedures.
 - They believed that they should have been informed more quickly of his admission to hospital.
13. The family received a copy of the draft report. The solicitor representing them wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

HMP HIGHPOINT

14. HMP Highpoint is on two sites: Highpoint South, which was the original HMP Highpoint, and Highpoint North, which was previously known as HMP Edmunds Hill. Highpoint holds up to 1,325 medium security risk adult men. The man was held at the Highpoint South site.
15. General healthcare services at HMP Highpoint are provided by Care UK. Norfolk and Suffolk Mental Health NHS Foundation Trust provides mental health services.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Highpoint was in September 2012. Inspectors reported that reception and first night practices at the prison were poor. Prisoner orderlies inappropriately interviewed new arrivals for first night risk assessments. First night cells were dirty and in a poor state of repair. However, they found that arrangements for caring for prisoners at risk of suicide or self-harm were generally good. Inspectors reported a high number of drug finds and positive drug testing rates and that the prison did not have a drug supply reduction strategy.

Independent Monitoring Board

17. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to December 2013, the IMB reported that Highpoint was a safe prison, although they were concerned that safer custody staff were often redeployed to other prison duties.

Previous deaths at HMP Highpoint

18. We investigated five deaths at Highpoint in the 18 months before the man died, three of which were apparently self-inflicted. In one investigation we found prison staff did properly consider the range of information and risk factors for suicide and self-harm. In another, staff did not call an emergency ambulance as quickly as they should have done.

HMP CHELMSFORD

19. HMP Chelmsford is a local prison that takes prisoners directly from court. It holds nearly 600 men. Care UK provide primary healthcare. North Essex Partnership Foundation Trust (NEPFT) provides integrated drug treatment service (IDTS) nurses.

HM Inspectorate of Prisons

20. HM Inspectorate of Prisons inspected Chelmsford in June 2014. Inspectors found that most prisoners they surveyed felt safe and concluded that initiatives to reduce violence and bullying were effective. Inspectors also

found reasonable arrangements to support those at risk of suicide and self-harm. They found that staff opened a comparatively high number of ACCT documents, but fewer than at the last inspection. Many of these were opened for newly arrived prisoners.

Independent Monitoring Board

21. In its latest annual report, for the year to August 2013, the IMB commented on the positive atmosphere and general feeling of safety in the prison. The IMB commended the prison's safer custody and violence reduction teams for their role in reducing conflict and keeping prisoners safe.

Previous deaths at HMP Chelmsford

22. We investigated four apparently self-inflicted deaths at Chelmsford in the year before the man died. In our reports into the two most recent deaths, we made recommendations about the identification of risk factors for suicide and self-harm in reception and early days in custody.

ACCT - Assessment, Care in Custody and Teamwork

23. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be irregular to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves drawing up a care map 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 of the actions on the care map have been completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

KEY EVENTS

24. The man had been in prison several times since the early 1990s. His family told us that he had previously taken an overdose in police custody, and his records indicate that he had attempted to hang himself in prison. (The exact date is unclear, but this appears to have been in the late 1990s or early 2000s.) He was supported by ACCT procedures on several occasions; the most recent was for a short time in 2011.
25. The man's previous most recent prison sentence was from December 2011 to January 2013, during which he had completed an opiate reduction programme, as he had done several times before. The family solicitor told us that a drugs worker, who had worked with him in prison and the community at this time, told her that he alleged that when he had been in prison in 2012, a cellmate had seriously sexually assaulted him. The drugs worker did not respond when we contacted her for further information and there is no record that the man reported an assault to prison staff or the police at the time.
26. On 4 March 2014, the police arrested the man for drugs offences. At the time, he was prescribed methadone (an opiate substitute used to treat heroin addiction) and said that he used diazepam (a sedative). He told the police that he had previously cut himself and attempted to hang himself. The man's police custody record indicates that these incidents were between 1996 and 2002. He said that he had no current intention to harm himself.
27. On 5 March, the man appeared at Magistrates' Court and was remanded to HMP Thameside. The police noted in the Person Escort Record (PER, a form that accompanies prisoners on all journeys to communicate information including about risk factors) that he had previously tried to hang or strangle himself and that he was a heroin user with a methadone prescription.
28. Reception staff at Thameside saw the information in the escort record, but did not open an ACCT document. A prison nurse carried out a routine health screen in reception. He incorrectly noted that the man had no history of self-harm and had not previously been managed on ACCT procedures. The man told the nurse that he had no current thoughts of self-harm or of suicide. The nurse noted his history of drug use and referred him to a prison doctor, who prescribed diazepam (for benzodiazepine withdrawal treatment) and methadone.
29. In line with his treatment programme, the man's methadone dose was reduced twice at Thameside and he completed his diazepam course. At an integrated drug treatment service (IDTS) review on 3 April, he said that he was depressed because he had been sexually abused in the past. A prison doctor prescribed mirtazapine (an antidepressant).
30. The man appeared at Crown Court on 8 April. An officer wrote in the risks section of the PER that he was a "self-harmer in custody" and the phrase "self-harmer" was also written on the front of the form. (It is not clear who wrote this.) The man was convicted of supplying drugs and was remanded to

HMP Chelmsford to await sentencing. When told that he was going to Chelmsford, he reportedly told his solicitor "I might as well top myself now". As a result, court staff completed a suicide and self-harm warning form that went with his escort record to Chelmsford.

31. An officer carried out a reception self-harm risk assessment at Chelmsford and asked the man about the information in the suicide and self-harm warning form. The man said that he had made the comment in frustration and anger and that he had meant nothing by it. However, he said he was concerned about potential reprisals from other prisoners at Chelmsford who were involved in his case. He said that he could not remember their names. The officer reported this conversation to the prison's violence reduction team but did not begin ACCT support. He told us that this was because the man was adamant that what he had said in court was a throwaway comment and he had been reassured that the previous officer had referred his concerns to the violence reduction team.
32. A nurse completed a reception health screen and noted that the man was on a methadone reduction programme. He said that he had tried to harm himself in prison about five years previously. The nurse did not explore this further. The nurse asked the man about the contents of the suicide and self-harm warning form and the man told him that he had made the comment in anger and that he did not mean it. However, he said that he had not wanted to come to Chelmsford as he might meet "an old enemy". He strongly denied any intention of harming himself and said he had a lot to live for. The nurse did not open an ACCT document. He told us that this was because the man appeared pleasant and calm, said he did not have any thoughts of suicide or self-harm and did not appear to be depressed or in a low mood.
33. The next day, 9 April, a Supervising Officer (SO) spoke to the man. (The SO interviewed all new arrivals who were monitored on an ACCT or who came in with a suicide and self-harm warning form.) They discussed the warning form and he told her that he had previously harmed himself in prison. The man said that this had usually been when he was had not coped well with withdrawing from drugs but he felt better about this, this time. He did not think he needed monitoring under ACCT procedures. She told us that she did not open an ACCT because he had said that he felt stronger and better able to cope with his withdrawal from drugs.
34. At a secondary health screen on 9 April, the man told a nurse that he had attempted suicide in the past, but did not have any current thoughts of doing so.
35. On 11 April, the man told an officer that he was worried about leaving E wing, the drug treatment unit. He said that he was scared of some drug dealers in the prison, who he thought blamed him for their imprisonment. He said he only knew their nicknames and did not want to give those to the officer. The officer submitted a security intelligence report. No further action was taken but he was allowed to stay on E wing.

36. On 15 April, the man told an officer, a member of the violence reduction team, that he had issues with various people in the prison, due to a drug deal which had gone wrong outside the prison. He knew that some of these prisoners were on C wing. He said that he did not know their names, but this time gave three nicknames. He said that he felt safe on E wing but was worried about meeting these people elsewhere in the prison.
37. On 17 April, a prison doctor reviewed the man in the drug treatment clinic. The man explained that he had harmed himself in the past and told the doctor that he had recently had some suicidal thoughts but that these were not serious. He said that he did not think he needed to be managed under ACCT procedures. The doctor told us that the man related his thoughts to incidents that had happened at his previous prison. As he had moved away from the source of the distress, the doctor did not think that he needed to begin ACCT monitoring. He did not mention to the doctor his fears about his safety at Chelmsford, but said that his antidepressant medication was not working and asked for the dose to be increased. The doctor diagnosed him with a mixed anxiety and depressive disorder and agreed to increase the dose.
38. The man's methadone dose was reduced each week in line with his detoxification programme. At a review on 23 April, he said he was keen to reduce the dose more quickly, but agreed to follow the programme of staged reduction. He was supposed to attend the prison gym on 29 April as part of his drug programme but refused to go because he was worried about coming into contact with the other prisoners.
39. On 8 May, a nurse saw the man to review his methadone programme. He had not attended a healthcare appointment earlier that day, because he was worried about leaving E wing. The nurse told us that he advised the man to speak to prison officers about this. They discussed the last stages of his methadone detoxification programme and what support he would get when it finished. He was on a low dose of methadone, which he agreed to remain on before stopping the course. The nurse told us that the man was very motivated to complete the programme to become drug-free and was getting on well with it.
40. On 14 May, the man was sentenced to three and a half years imprisonment at Crown Court. The nurse who assessed him in reception when he got back from court noted that the man was calm and did not raise any concerns. The man later spoke to an SO and said that he wanted to transfer out of the prison as soon as possible because he thought there were people after him at Chelmsford. The SO noted this in the wing observation book but it does not appear that he took any further action.
41. The man finished his methadone detoxification programme on 19 May. A doctor prescribed him zopiclone (a sleeping tablet) and other medication to use as required to relieve the side effects sometimes associated with stopping methadone.

42. On 23 May, the man transferred to Highpoint. This was a standard transfer to a training prison because he was now a sentenced prisoner. An officer told him about the transfer in the morning and recorded that he was not enthusiastic about the move, as he would have preferred to go to HMP The Mount.
43. Before leaving Chelmsford officers strip-searched the man in line with standard procedures. The escort vehicle left Chelmsford at 11.35am and arrived at Highpoint at 12.45pm. Staff did not refer to any risk of suicide or self-harm on his escort record. When he arrived at Highpoint, staff gave him a rub down search and did not find any illicit items or drugs.
44. A nurse completed the man's reception health screen at Highpoint. She discussed his diagnosis of depression with him and he said that he did not want to be referred to the prison's mental health team. The nurse said she could not remember if they discussed the history behind this diagnosis, but she was aware of, and considered, his history of self-harm. She noted that the man had recently completed a methadone detoxification programme. She told us that he said that he felt very positive about this and thought he was turning a corner. She did not consider that he was at risk of suicide or self-harm.
45. Each newly arrived prisoner should have a first night assessment at Highpoint to identify any immediate needs, including language issues, disabilities, vulnerabilities and risk of suicide or self-harm. Highpoint's local policy states that the First Night Locating Officer should carry out this assessment. The officer who had this role on 23 May told us that a prisoner orderly completed the man's assessment and that this was the standard practice at Highpoint. The officer said that his role was to collect new arrivals from reception and escort them to Unit Four (the induction unit). The orderly did not indicate any concerns in the assessment. The man's risk of suicide or self-harm was not considered as part of this assessment.
46. The man arrived on Unit Four at around 3.45pm. He was allocated a cell with another prisoner, who had also transferred from Chelmsford to Highpoint that day. The cellmate told the investigator that he had not known the man at Chelmsford as they were on different wings, but they had got on well when they were on the way to Highpoint, so asked to share a cell. An officer, who works on the induction unit, told the investigator that the orderlies in reception are also responsible for pairing up prisoners to share cells.
47. The man and his cellmate were locked in their cell at around 5.00pm. At about 8.00pm, an officer answered their cell bell. The man said that he wanted to see a Listener (a prisoner who has been trained by Samaritans to support other prisoners in distress) as he was stressed and was "coming off his medication". The officer told us that he appeared to be fine and there was no sign that he was withdrawing from drugs. She told the man that she would speak to a senior officer about his request.

48. The officer said that she looked up the man's record on the computer, noted that he had harmed himself in the past and telephoned the prison's duty manager for advice. The duty manager told us that there were usually two Listeners on duty, but, that evening, one of the duty Listeners was with another prisoner and the other had decided not to see any more prisoners because he was about to be released and no longer wanted to work as a Listener. The duty manager advised the officer to offer him the use of the Samaritans telephone (a cordless phone that prisoners can use in their cell, which connects directly to the Samaritans). The Samaritans telephone on Unit Four was missing at the time and the duty manager said she would try to find another one for him. The officer said that she did not consider opening ACCT procedures because he told her he had no thoughts of harming himself.
49. The officer went back to see the man at around 8.20pm. She told him that there was no Listener available and that they were trying to find a Samaritans telephone for him. She advised him to talk to his cellmate in the meantime. She said he appeared content about this. He told her he was hungry and had a headache. She gave him a breakfast pack, but said she could not give him any medication for his headache and he would need to speak to healthcare staff the next morning if he still felt unwell. (There is no healthcare cover at night at Highpoint.) The officer told us that the man appeared relaxed at the time and was sitting on the top bunk watching television.
50. At 8.30pm, the night patrol officer, (an operational support grade - OSG), arrived. The officer handed over to him and told him that the man had asked to see a Listener. The OSG carried out a security check at around 8.45pm to ensure that all prisoners were present in their cells, but did not recall seeing or speaking to the man at the time.
51. At around 10.00pm, a custodial manager, who was the night orderly officer, in charge of the prison that night, brought a Samaritans phone to the unit. Two assistant night orderly officers accompanied her. Officer A unlocked the cell to give the man the phone, while the custodial manager and Officer B waited nearby. Officer A said that the cellmate asked what would happen if the man swallowed a razor blade and speculated that he would have to go to hospital. Officer A said he told him that officers would open an ACCT document but the man would not necessarily go to hospital. He said that he did not ask the man how he was at the time, but that he seemed all right.
52. The cellmate told us that he and the man had told the officer that the man had swallowed a razor blade, although he had not. He said that he had thought the man was "attention seeking" and needed time out of the cell, which is why he supported his story. The custodial manager and Officer B could not recall hearing any conversation during this visit to the cell and thought that Officer A simply handed over the telephone.
53. The cellmate told us that the man phoned the Samaritans but did not speak to them for long. He said that the man told the Samaritans that he was in prison, was withdrawing from drugs, had a headache and felt like cutting himself.

54. The custodial manager and Officer B told us that they went to the unit office and shortly afterwards noticed that someone had pressed the cell bell in the man's cell. Officer B said this was two or three minutes after they had left the cell, but Officer A thought that it was considerably longer than that. Highpoint does not have an electronic system to record when cell bells are pressed and answered. There is also no CCTV coverage of the unit so we were unable to verify this and other timings that night. Both officers went to the cell and the custodial manager stayed in the office.
55. Officer A said that the man was holding a razor blade and asked if they would move him to a single cell if he cut himself. He said that the cellmate did not say anything. He said that he told the man that, if he cut himself, he would open an ACCT document and that officers would check him through the night, but that he could not move to a single cell as they did not have any and he would have to speak to wing staff about this in the morning. He did not ask him why he might cut himself or why he wanted to move cells. He said that his view was that this was a ploy to try to get a single cell and so he did not consider opening an ACCT document.
56. Officer B's account was slightly different. She said that the man had asked what would happen if he swallowed a razor blade and had speculated that he would have to go to hospital and be given a single cell. She did not ask him why he might do this. In contrast to Officer A, she said that it was the cellmate who did most of the talking.
57. Officer B said that, when they returned to the unit office, someone pressed the cell bell again and they went back to the cell for a third time. Officer A thought they had only gone to the cell twice. Officer B said that the man again said he wanted to move to a single cell and, as before, she told him that night staff could not arrange this. Shortly afterwards the custodial manager, Officer B and Officer A left the unit.
58. The OSG said that he responded to the cell bell again at some point after the officers had left the unit, but he did not know at what time. He said that the man asked to move to a single cell but gave him no reason when he asked why. He said that his behaviour appeared normal and he said nothing about swallowing or cutting himself with a razor blade. He said that the cellmate was sitting on the lower bunk and said nothing. He reminded the man that he had the Samaritans phone if he need to speak to anyone else and said he would speak to the wing officers in the morning about his request to move cells.
59. The OSG answered the cell bell again around 25 to 30 minutes later and the man again asked for a single cell. He gave the same response as before and said that the man still appeared and behaved normally.
60. The OSG said that he responded to the cell bell again at around 11.40pm, although other accounts of what followed suggest that this might have been earlier. When he came to the cell, he said the man was lying on the floor and

the cellmate told him that he had collapsed. The cellmate told us that the man had a towel wrapped around his neck, but the OSG said he did not see this. He said that he could see the man was breathing, but he did not acknowledge him at all or respond to him. He said that he then went to the office to phone the prison's control room to report what had happened. This call was not recorded and none of the staff present in the control room at the time remembered the call. He said he had reported what had happened to the controller and his colleagues told him they would decide whether to send assistance.

61. The OSG said he went back to the cell and found that the man was now standing up. He said that he had swallowed a razor blade but was not unwell. The OSG said that he appeared calm and there was no blood coming from his mouth. He went back to the office and phoned the control room again. He spoke to the control room operator, who relayed the message to Officers A and B, who were with her. Officer A advised the OSG to begin ACCT procedures. The control room operator thought that this call was at around 11.45pm, whereas both officers placed it at 11.30pm. No one made a record of it at the time.
62. The OSG could not find any ACCT documents in the unit office and phoned the control room again. Officer A told him where the documents were stored and he began to fill in the document.
63. The cellmate told us that he fell asleep after the OSG had left the cell. He said that he woke up shortly afterwards and realised that the man was hanging from the top rail of the bunk bed with a strip of bed sheet around his neck. He pressed the cell bell. The OSG told us that he responded to the cell bell at about 11.55pm.
64. The OSG said that when he got to the cell he looked through the observation panel and saw the man hanging. He could not tell if he was breathing. He asked the cellmate to try to cut the ligature and went back to the unit office to phone for help. He told us that he did not use his radio because he did not want other prisoners to overhear the message. He did not use an emergency code, but told us that he had said that the man had ligatured, was hanging from the bed and that he wanted assistance straightaway. In her incident statement, the control room operator said that the message she took was that the man had something around his neck. The custodial manager and Officers A and B, who were all present in the control room, agreed that this was the message relayed to them. They went to Unit Four to assist.
65. While the OSG phoned for assistance, the cellmate used a razor blade to cut the sheet from the bed frame. He said that he tried to poke the man but got no response and thought he was unconscious. He said that he then sat at the other end of the cell.
66. When the OSG came back after phoning for help, he said that the man was now slumped on the floor with his head forward. He could not tell if he was conscious or breathing. He told us that he did not open the cell before other

staff arrived because there were two prisoners in the cell and he did not think it would be safe.

67. The custodial manager estimated that it took her and her colleagues between four to five minutes to get to the cell. Officer A unlocked the cell and found the man sitting at the base of the bed. The piece of sheet was still around his neck and the officer cut it off. The custodial manager found a faint pulse but he did not appear to be breathing. Officer C arrived on the unit and asked the control room to call an emergency ambulance.
68. Officer A took the cellmate out of the cell and put him in a cell across the landing with another prisoner. He then went back and he and Officer C began cardiopulmonary resuscitation. The custodial manager brought a defibrillator, which they attached to the man, but the defibrillator did not find any shockable heart rhythm. The officers therefore continued cardiopulmonary resuscitation.
69. East of England Ambulance Service records show that the prison requested an ambulance at 12.05am and the ambulance arrived at the prison at 12.30am. It was a further 12 minutes before the paramedics reached the man. The custodial manager explained that this delay was partly caused by the number of vehicle gates that had to be unlocked, opened and locked again between the entrance and Unit Four and also because the ambulance initially went the wrong way through the prison. She said that she gave the ambulance crew directions when they arrived but that they made a wrong turn and she had to chase the ambulance to correct them.
70. When the paramedics arrived at the cell, they took over emergency treatment. After nearly an hour treating the man, they took him to hospital. He arrived at 2.05am and was placed on a life support machine in the intensive care unit.

Contact with the man's family

71. At around 3.15am, the custodial manager phoned the duty governor to tell him that the man was on a life support machine and that hospital doctors had told them that it would be switched off later in the morning. The duty governor asked her to begin the prison's contingency plans for a death and told her to contact the duty officer at the National Operations Unit (NOU, which records, reports and manages significant incidents across the prison estate). She said that the NOU duty officer told her to call back if he died. The duty governor said that he understood that the NOU duty officer had told the custodial manager not to contact the next of kin, although she said that she did not recall this. She said that the duty governor had advised her to ask the police to contact the man's family in London.
72. Two Metropolitan Police officers visited the man's mother at around 6.30am to tell her that her son was in hospital. She telephoned the hospital and spoke to a nurse about her son's condition. When he died, a hospital nurse phoned his mother shortly afterwards to inform her. No one from the prison spoke to her until she telephoned Highpoint just after 10.00am. The prison's family

liaison officer then spoke to her and went to see his family that afternoon to express condolences and explain what had happened.

73. The funeral was held on 18 June and the prison contributed to the costs in line with national guidance.

Support for staff and prisoners

74. All of the prison staff who were involved in the emergency response that night told us that they received either insufficient or no support afterwards. No one debriefed the staff shortly afterwards, to allow them to discuss what had happened and offer immediate support, but a manager held a critical incident debrief later in the week.
75. Prison staff moved the cellmate to a cell with a friend who could support him and allowed him a free telephone call to his mother. Staff spoke individually to prisoners who were being managed under ACCT procedures in case they had been affected by the news of the man's death.

Security intelligence submitted after the man's death

76. On 30 May, a prisoner told an officer that the man's cellmate had spoken to him about the events of the night of 23 May. The prisoner said that the cellmate had told him that he had encouraged the man to take all of his zopiclone at once and that they had then started smoking spice (a synthetic cannabis substitute that can be considerably stronger than cannabis). The cellmate told the prisoner that the man had begun hallucinating and that he had started "winding [the man] up" by saying that there were dogs under the bed.
77. The cellmate told the prisoner that he and the man ran out of tobacco to mix with the spice so he told the man to pretend he had harmed himself and staff might give him extra tobacco. When this did not work, he told the man to try putting a ligature around his neck. He said that he then pretended to be asleep and the next he knew, the night patrol had told him to cut the ligature. When we spoke to him about this account, he denied that they had smoked spice or used any other drug. He said that the man did not appear to be under the influence of drugs. He said he did not know if the man took any of his zopiclone. He said that he had drifted in and out of sleep for a while and that he had been asleep when the man tied the ligature around his neck. The police who investigated were satisfied that there were no suspicious circumstances in relation to the man's death.

Post-mortem report

78. A post-mortem examination established the cause of the man's death as hanging. Toxicology tests did not identify spice in his blood, although the examiner noted that they were unable to test for all variants of this. The tests identified one drug that he was not prescribed, a barbiturate called thiopental that is used as a short-term anaesthetic. The pathologist commented that this

was likely to have been used as part of his emergency treatment, although the hospital later said that they did not administer this drug. We do not therefore know when or how he received thiopental. The toxicology test did not include a screen for zopiclone.

ISSUES

Identification of risk of suicide and self-harm at HMP Chelmsford

79. Staff judgement is fundamental to the ACCT system. ACCT relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. They must balance this against the prisoner's known risk factors and their presentation. Prison Service Instruction (PSI) 64/2011 contains a list of risk factors for suicide and self-harm and 'triggers' or events which might increase the risk. The list of risk factors includes previous deliberate self-harm and mental illness. Substance misuse or detoxification is noted as a trigger which can increase the risk.
80. When he arrived at Chelmsford on 8 April, a number of these factors applied to the man. He had previously attempted to take his life in prison, had been diagnosed with depression, and was withdrawing from drugs. Significantly, a suicide and self-harm warning form had been opened that day at court when he had said, "I might as well top myself" when he learnt he was going to Chelmsford.
81. An officer and a nurse saw the man on the night he arrived at Chelmsford. He said that his remarks at court had been a throwaway comment but he was concerned about the possibility of reprisals from other prisoners who were involved in his case. The officer made arrangements to protect the man. The officer and the nurse both considered his previous self-harm and the information on the suicide and self-harm warning form but satisfied themselves that, despite the risk factors, he did not need be monitored under ACCT suicide and self-harm prevention procedures. The next day, as a further check, a supervising officer interviewed the man because he had arrived with a suicide and self-harm warning form. She discussed his risks with the man, who said he had previously self-harmed when he had had difficulty withdrawing from drugs but this was not the case this time. The supervising officer was satisfied that she did not need to open an ACCT.
82. A prisoner's presentation can reveal something of their level of risk. However, it is only a reflection of their state of mind at the time they are seen by the member of staff and should be considered as a single piece of evidence used to make a judgement of risk. All risk factors must be collated and considered to ensure that a prisoner's level of risk is holistically judged. While this was a finely balanced decision, the staff took into account the man's risk factors and discussed them with him. Particularly given the supervising officer's further assessment the next day, we are satisfied that it was not unreasonable for the staff to conclude that he did not need to be monitored under ACCT procedures when he arrived at Chelmsford.

Clinical care and detoxification

83. When the man was remanded to prison in March 2014, he had been prescribed methadone in the community and continued his methadone programme at Thameside. When he moved to Chelmsford, he told prison and

healthcare staff that he was coping well with his withdrawal and he was keen to reduce his methadone dose. A nurse told us that he was very motivated to complete the programme and was getting on well with it. A friend of his also said that the man was motivated to do well for himself.

84. The clinical reviewer was satisfied that the man's methadone detoxification programme was undertaken appropriately and with his full engagement.

First night assessment at HMP Highpoint

85. Highpoint's local Reception, First Night and Induction policy states that the first night locating officer should interview all new arrivals individually in a private room. The policy sets out that this interview should be in reception, but can take place on the induction unit if time constraints do not allow this. The first night locating officer should complete the 'first night duty sheet'. An example of this form is included as an annex to the policy and contains questions about the prisoner's risk of suicide or self-harm and their vulnerability. A separate 'safer custody induction screening' form should be completed for those prisoners identified as being at risk.
86. The first night assessment form completed for the man differed from the example in the policy, as it did not contain any questions about his risk of suicide or self-harm. We are concerned that it was completed by another prisoner rather than an officer. The officer, who was first night locating officer on 23 May, told us that a prisoner orderly usually completes the form and his role is simply to collect newly arrived prisoners from reception and take them to Unit Four. We were also told that prisoner orderlies arrange cell sharing for new prisoners.
87. We do not consider it appropriate that prisoner orderlies should complete first night assessments, which are partly designed to highlight a prisoner's risks and vulnerabilities. While prisoner peer supporters can play an important role in welcoming new arrivals, giving them information and helping them settle, it should be the responsibility of prison staff to ensure that prisoners are properly assessed and to make appropriate referrals.
88. At their inspection in September 2012, HM Inspectorate of Prisons commented that this practice was "insensitive and unsafe". The Inspectorate identified first night arrangements as one of its main concerns and made a recommendation about this, yet the practice of prisoners completing some assessments appears to have continued. The Inspectorate noted that this practice meant that staff missed the opportunity to assess and support prisoners when they were at their most vulnerable and we agree. While the prisoner orderly did not assess for risk of suicide and self-harm, as part of the first night assessment, neither did anyone else.
89. The man's family were concerned that his cellmate at Highpoint was a prisoner who had also come from Chelmsford and that he might have continued to fear for his safety at Highpoint. We note that his cellmate lived on C wing at Chelmsford, which is where he said his 'enemies' were located.

However, none of the nicknames that he provided on 15 April matched the names by which the cellmate was thought to be known by and there is no indication that he knew him before he went to Highpoint. Nevertheless, a full and proper first night interview with a member of staff might have given him the opportunity to raise any concerns he might have had for his safety at Highpoint. It is inappropriate that prisoner orderlies allocate new prisoners to shared cells. A member of staff should do this. We make the following recommendations:

The Governor should ensure that first night interviews include an assessment of the risk of suicide or self-harm and are completed by a prison officer, in line with local policy.

The Governor should ensure that a member of staff is responsible for allocating cells.

Risk of suicide and self-harm on 23 May

90. The exact events of evening of 23 May are unclear and accounts vary, but we can summarise those events before the emergency response as below:

- The man asked to speak to a Listener at around 8.00pm, but there were none available at the time. He told an officer that he was “stressed” due to his withdrawal from drugs.
- Officer A, accompanied by Officer B and a custodial manager, delivered the Samaritans telephone to the man at around 10.00pm.
- On two or three occasions around this time, the man and his cellmate questioned what would happen if he were to swallow or cut himself with a razor blade. They speculated that he would go to hospital or be given a single cell. The officers told them that there were no single cells and that they would open an ACCT document if he harmed himself.
- On two further occasions in the next hour or so, the man asked the night patrol for a single cell. The OSG did not identify this as a potential sign of vulnerability.
- Around 11.30pm to 11.45pm, the man told the OSG that he had now swallowed a razor blade. After consulting colleagues, the OSG began to complete an ACCT document.

91. The man asked to speak to a Listener at around 8.00pm. Of the two Listeners scheduled to work, one was busy with another prisoner and the other had that night decided to no longer work in the role. Highpoint’s Local Protocol for Listener Scheme and Samaritans states the duty Listeners only will be used unless otherwise authorised by the duty governor or safer custody team leader or deputy. An officer told us that she intended to check which Listener was next on the rota and see if he could speak to him, but another officer told her that he was happy to speak to his cellmate instead. She therefore did not

take any further action. As he had always been able to speak to his cellmate, we consider this was an inappropriate response.

92. When the man asked to speak to a Listener, an officer checked his prison records and noted that he had risk markers for previous self-harm. She told us that she did not open ACCT procedures as he said he did not feel like harming himself.
93. Officers did not take any action when the man later spoke about potentially harming himself. No one asked him why he might want to swallow a razor blade or cut himself or asked him how he was - before or after he had spoken to the Samaritans. The officers assumed that this was either a ploy to be given a single cell – without questioning why he might want one – or that he and his cellmate were testing the boundaries to see what they could get away with at their new prison. No one checked his prison record at the time. (Although this had happened earlier, it does not appear that the information was passed on.) This would have quickly revealed that he had risk markers for self-harm.
94. Although the man was able to telephone the Samaritans, he was in a shared cell, which did not allow him to speak to them confidentially. None of the officers thought to take him out of the cell and give him the opportunity to speak to them or the Samaritans in confidence. He had asked for a single cell, which might have indicated he was not comfortable with his cellmate and would not wish to discuss this in his hearing. Highpoint's Local Protocol for Listener Scheme and Samaritans states that a Listener Suite is available on Unit Four. It does not appear that officers considered using it.
95. We do not know why the man talked about harming himself, but we consider that prison staff should have been more alert to signs that he was at risk as it was his first night at the prison, which is recognised to be a vulnerable time. He had asked to speak to a Listener and the Samaritans and the officers knew nothing of his background. We consider that the custodial manager and the two officers on duty that night should have acknowledged that his actions indicated a possible risk of suicide or self-harm and should have opened an ACCT document earlier. This might have led them to monitor him more closely over the course of the night. While we cannot say that it would have led to a different outcome, it would have given prison staff more chance of preventing the later events.
96. When the OSG later told the night orderly officers that the man said he had swallowed a razor blade, they advised him to open an ACCT. No one sought medical advice. The OSG told us that he had never been trained in ACCT procedures and he had to phone back for advice as he did not know where the ACCT documents were kept. We are concerned that an untrained, junior member of staff was asked to open ACCT procedures by himself without support. One or more of the night orderly officers should have considered going straight to the unit to support him. They should also have sought medical advice. Although there was no grounds at the time to think that the man was of immediate risk of suicide, this would have allowed a member of

staff to stay with and support him while the other completed the practical aspects of opening ACCT procedures. We make the following recommendations:

The Governor should ensure that all prison staff are aware of their responsibilities to manage prisoners at risk of suicide or self-harm in line with national guidelines, including reviewing and considering all risk information whenever a prisoner indicates that they are thinking of harming themselves and opening an ACCT when indicated.

The Governor should ensure that all staff in contact with prisoners are trained in ACCT procedures, in line with the requirements of PSI 64/2011.

The Governor should ensure that all prisoners are able to see Listeners promptly and have appropriate alternative support if a Listener is not available.

Emergency response

97. Prison Service Instruction (PSI) 03/2013 *Medical Emergency Response Codes*, issued in February 2013, sets out the actions staff should take in a medical emergency. It contains mandatory instructions for governors to have a protocol to provide guidance on efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It stipulates that if an emergency code is called over the radio, an ambulance must be called immediately. Staff should ensure there are no delays in calling an ambulance and that it should not be a requirement for a member of the healthcare team or a manager to attend the scene before an ambulance is called.
98. Highpoint's local instruction on medical emergency response codes (Governor's Order 08/2013) instructs the use of the emergency codes 'red' and 'blue' to comply with PSI 03/2013. Examples of the circumstances in which code blue should be used are when the prisoner has difficulty breathing, is unconscious or is fitting or concussed.
99. The OSG went to the cell at around 11.30pm and found the man lying on the floor. His cellmate said that the man had collapsed. The OSG told us that he could see that he was breathing, but that he was unresponsive and he had no reason at the time to doubt that he had collapsed. He told us that he telephoned the control room to report the collapse, although there was no record of his call. While the man's later actions, and the cellmate's statement to the investigator, suggest this 'collapse' was a hoax, the OSG believed it was real at the time. If so, we consider he should have radioed a code blue alarm.
100. About 20 minutes later, the cellmate said that he woke up and found the man hanging from a ligature attached to the bed frame. Another prisoner claims that the cellmate told him that he was not asleep at the time. He denies he

said this and we cannot know exactly what happened in the cell during this period.

101. The cellmate pressed the cell bell and the OSG found the man apparently unconscious and hanging from the bed frame. The time was now around 11.55pm. At that point, the OSG should certainly have radioed a code blue. Instead, he telephoned for help and there appears to have been some confusion about the nature of the emergency. When staff carry radios they should use them to communicate an emergency as this is the most effective means. The failure to use an emergency code also meant there was a delay of several minutes before an ambulance was called. When the ambulance did arrive at Highpoint, it moved slowly towards the cell because prison staff had to unlock interim prison gates, which should have been arranged before the ambulance arrived to allow swift access. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of PSI 03/2013 and Governor's Order 08/2013 and that they understand their responsibilities during medical emergencies, including:

- **Using the appropriate emergency code, by radio where possible, to effectively communicate the nature of a medical emergency.**
- **Ensuring staff called to the scene bring the relevant equipment; and**
- **Ensuring there are no delays to calling, directing or discharging ambulances.**

102. When he returned to the cell, the OSG found the man sitting on the floor with his head forward. (The cellmate had by then cut the ligature from the bed.) The OSG told us that he could not tell if the man was conscious or breathing. He did not open the cell but waited for other staff to arrive about four or five minutes later. Because there were two occupants in the cell, he did not think it would be safe to do so.
103. Highpoint's local instruction for opening cells at night (local instruction 2.77) states that preservation of life must take precedence over security concerns but that night staff should not take action that they feel would put themselves or others in unnecessary danger. When there is, or appears to be, immediate danger to life, an individual member of staff can open a cell on their own.
104. We appreciate that the OSG faced a difficult decision. The man and his cellmate had been challenging during the night and, shortly beforehand, he had apparently pretended to collapse. Taking into account the events of earlier in the evening, we can understand why the OSG decided to wait for other staff to arrive and we do not criticise that decision.

Family liaison

105. No one informed the man's family that he had been admitted to hospital until some hours later and the communication was from the police and not the prison.

106. There appeared to have been some confusion in communication between the night orderly officer and the duty governor about arrangements for informing the man's family that he had been taken to hospital in a critical condition. Eventually, at 5.00am, the duty governor asked the night orderly officer to ask the police to inform the family. It was not until 6.30am that two police officers visited the man's mother. She spoke to nurses at the hospital several times in the next few hours, and it was a hospital nurse who told her of his death. It was she who instigated contact with the prison later that morning. Until then no one from the prison had been in touch.
107. We consider there should have been no doubt about contacting the man's family as soon as he was taken to hospital. Prison Rule 22 requires prisons to inform the next of kin immediately if a prisoner dies or is seriously ill. This clearly applied in these circumstances. He was in a critical condition and someone from the prison should have contacted his mother by telephone quickly after he was taken to hospital. It was also inappropriate that no one from the prison spoke to the man's mother until she initiated contact. We make the following recommendation:

The Governor should ensure that next of kin are notified as soon as possible when a prisoner becomes seriously ill.

Debriefing and staff support

108. PSI 64/2011 requires a debrief to be held immediately after all deaths in custody, to be led by a senior member of staff and with a member of the prison's care team present. The purpose of the debrief, after a death or any traumatic incident, as set out in PSI 08/2010, is to 'acknowledge what happened, acknowledge the role of the staff involved, normalise the situation and ensure the immediate needs of the staff involved have been met'. A critical incident debrief must also be held within five to ten days of the death, to provide further ongoing support and access to support networks.
109. All of the staff who were involved in the emergency response told us that they received insufficient or no support afterwards. They said that there was no debrief immediately after the emergency or on the day that the man died. A critical incident debrief was held later in the week, but those present who were involved in the emergency response told us they found it ineffective.
110. We told the Governor of the staff's concerns. His view was that the prison had provided sufficient and effective support. However, it is clear that the staff involved thought differently. We have investigated deaths where staff have not reacted well to emergencies because trauma from previous incidents had not been acknowledged or addressed. Sadly, experiencing traumatic events at work is a risk for many prison staff. Managers have a duty of care to ensure that staff are well supported after these events for the sake of their own personal welfare, but also for the safety of other prisoners and to help ensure that an unaddressed traumatic experience does not lead to staff responding badly in future emergencies. We make the following recommendation:

The Governor should ensure that that after a prisoner's death, timely and effective debriefs are carried out, in line with national guidelines, and that all staff involved are fully supported.

RECOMMENDATIONS

1. The Governor should ensure that first night interviews include an assessment of the risk of suicide or self-harm and are completed by a prison officer, in line with local policy.
2. The Governor should ensure that a member of staff is responsible for allocating cells.
3. The Governor should ensure that all prison staff are aware of their responsibilities to manage prisoners at risk of suicide or self-harm in line with national guidelines, including reviewing and considering all risk information whenever a prisoner indicates that they are thinking of harming themselves and opening an ACCT when indicated.
4. The Governor should ensure that all staff in contact with prisoners are trained in ACCT procedures, in line with the requirements of PSI 64/2011.
5. The Governor should ensure that all prisoners are able to see Listeners promptly and have appropriate alternative support if a Listener is not available.
6. The Governor should ensure that all prison staff are made aware of PSI 03/2013 and Governor's Order 08/2013 and that they understand their responsibilities during medical emergencies, including:
 - Using the appropriate emergency code, by radio where possible, to effectively communicate the nature of a medical emergency.
 - Ensuring staff called to the scene bring the relevant equipment; and
 - Ensuring there are no delays to calling, directing or discharging ambulances.
7. The Governor should ensure that next of kin are notified as soon as possible when a prisoner becomes seriously ill.
8. The Governor should ensure that that after a prisoner's death, timely and effective debriefs are carried out, in line with national guidelines, and that all staff involved are fully supported.

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 first night interviews include an assessment of the risk of suicide or self-harm and are completed by a prison officer, in line with local policy	Accepted	<p>Recommendation accepted and implemented with immediate effect.</p> <ul style="list-style-type: none"> • Governor's responsible for reception, Residence and Induction have been written to by Governor of Highpoint on 10 February to cascade to all their staff, information that first night interviews must include an assessment of the risk of suicide or self-harm and are completed by a prison officer, in line with local policy. • Reception staff informed as appropriate, and Governors Order issued 27 February alerting staff of this. • First Night Insiders Reception Questionnaire amended to ensure that first night interviews include an assessment of the risk of suicide or self-harm. • A specific officer is now detailed to carry out all of the first night interviews including all appropriate assessments. 	<p>Completed</p> <p>Reception, Operations and Residential Governors</p>	
2	The Governor should ensure that a	Accepted	Recommendation accepted and implemented with	Completed.	

Action Plan

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
	member of staff is responsible for allocating cells.		<p>immediate effect.</p> <ul style="list-style-type: none"> • The Governor at HMP Highpoint wrote to Governors responsible for Reception, Residence and Induction on 10 February to ensure that they update staff that a member of staff is responsible for allocating cells. Reception and Induction Unit staff have been informed as appropriate. Governors Order also issued 27 February alerting all staff to changes in process. • First Night Insiders Reception Questionnaire has been amended to reflect updates on changes, namely that a member of staff is responsible for allocating cells. • A Specific officer is now detailed to carry out all of the first night interviews including all appropriate assessments. This officer will also ensure that all prisoners are allocated a suitable cell. 	Operations and Residential Governors	
3	The Governor should ensure that all prison staff are aware of their responsibilities to manage prisoners at	Accepted	<ul style="list-style-type: none"> • An ongoing monthly training programme will be introduced in March 2015, focused on 	Target date: 31 March 2015 and	

Action Plan

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
	risk of suicide or self-harm in line with national guidelines, including reviewing and considering all risk information whenever a prisoner indicates that they are thinking of harming themselves and opening an ACCT when indicated.		<p>training staff on Assessment Care in Custody and Casework (ACCT) procedures in line with PSI 64/2011.</p> <ul style="list-style-type: none"> As part of this programme prison staff will be made aware of their responsibilities to manage prisoners at risk of suicide or self-harm in line with national guidelines, including all aspects of risks associated. This will be supported with a Notice to Staff, which will be issued by 30/3/15. 	<p>ongoing.</p> <p>Head of Corporate Services and Head of Residence.</p>	
4	The Governor should ensure that all staff in contact with prisoners are trained in ACCT procedures, in line with the requirements of PSI 64/2011	Accepted	<ul style="list-style-type: none"> A monthly ongoing training programme will be introduced in March 2015 that will focus on training staff in ACCT procedures in line with PSI 64/2011. 	<p>Head of Corporate Services and Head of Residence.</p>	
5	The Governor should ensure that all prisoners are able to see Listeners promptly and have appropriate alternative support if a Listener is not available.	Accepted	<ul style="list-style-type: none"> A Notice to Prisoners will be issued by 31/3/15 advising them of the service provision available and alternative support measures if the Listener Scheme service is not available. Notice to Staff will also be issued by 31/3/15 advising staff of the service requirements of 	<p>Target date for completion 31 March 2015.</p> <p>Governing Governor</p>	

Action Plan

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
			<p>the Listeners Scheme and their personal responsibility to ensure compliance.</p> <ul style="list-style-type: none"> This will also be linked to points 3 and 4 above and will form part of the training programme provided to staff. 		
6	<p>The Governor should ensure that all prison staff are made aware of PSI 03/2013 and Governor's Order 08/2013 and that they understand their responsibilities during medical emergencies, including:</p> <ul style="list-style-type: none"> Using the appropriate emergency code, by radio where possible, to effectively communicate the nature of a medical emergency. Ensuring staff called to the scene bring the relevant equipment; and Ensuring there are no delays to calling, directing or discharging ambulances. 	Accepted	<ul style="list-style-type: none"> PSI 03/2013 will be re-issued as a Notice to Staff (NTS) by 31 March 2015, reminding staff of their responsibilities during medical emergencies. Governors Order 08/2013 to be reviewed and also re-issued to all staff by 31/3/15 All Night Staff will receive individual briefing and a formal guidance sheet on procedures to follow during a medical emergency, by 31 March 2015. 	<p>Target date for completion: 31 March 2015</p> <p>Governing Governor</p>	
7	The Governor should ensure that next of	accepted	Recommendation accepted and implemented with	Completed	

Action Plan

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
	kin are notified as soon as possible when a prisoner becomes seriously ill.		<p>immediate effect.</p> <ul style="list-style-type: none"> 10 February 2015 - The Governor has personally written to all Senior Managers reminding them of their responsibilities with regards to notification of next of kin in these circumstances. NTS issued to all staff on 16 February advising of process to follow in these circumstances. 	Governing Governor and all SMT colleagues	
8	The Governor should ensure that that after a prisoner's death, timely and effective debriefs are carried out, in line with national guidelines, and that all staff involved are fully supported.	accepted	<p>Recommendation accepted and implemented with immediate effect.</p> <ul style="list-style-type: none"> 11 February 2015 – Governors Order issued to all staff instructing on debriefing and supporting staff following a death in custody. 10 February 2015 – The Governor has personally written to all Senior Managers reminding them of their responsibilities with regards to debriefing and supporting staff following a death in custody. 	Completed Governing Governor and all Senior Management Team colleagues	