PRISONS AND PROBATION OMBUDSMAN
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Independent investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man in December 2013 at HMP Durham

Our Vision

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

This is the investigation report into the death of a man, who was found hanging in his cell in HMP Durham on the morning of 28 December 2013. He was 45 years old. I offer my condolences to the man's family and friends.

An investigator was appointed. A clinical reviewer reviewed the man's clinical care in custody. HMP Durham cooperated fully with the investigation.

The man was remanded to Durham on 12 December 2013. The man had HIV and arrived at the prison without his anti-retroviral medication, but healthcare staff quickly obtained supplies and ensured that he had continuity of care with his consultant. His other medication, including an antidepressant, was confirmed by his GP the next day but not issued at that stage. The need for the antidepressant was not considered again at a medication review the day before he died. The man and his two co-defendants, one of whom was his civil partner, were kept apart from each other at the request of the police. During his time at the prison, the man did not give anyone any cause to consider he was in any distress or at risk of suicide and self-harm.

Early in the morning of 28 December, a prison officer found the man hanging. He radioed an emergency, but did not use the required emergency code which would have resulted in an ambulance being called automatically. The officer did not go immediately into the cell to cut the ligature from the man's neck, even when healthcare staff arrived, but waited for the night orderly officer in charge of the prison. However, when the staff went into the cell it was evident that the man had been dead for some time so they did not try to resuscitate him.

I am satisfied that the man received a reasonable standard of care in Durham, although I am concerned that a review of his medication was not scheduled until more than two weeks after he arrived and did not include his previously prescribed antidepressant. However, there was little to indicate that the man intended to take his own life and I do not consider that staff at the prison could reasonably have foreseen his actions or prevented his death. Although it was too late to save the man, I am concerned that there were a number of deficiencies in the emergency response which the prison needs to address.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **September 2014**

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SUMMARY

1. The man was remanded to Durham on 12 December 2013. He had served time in prison some years before. A police medical detainee form among the man's files seems to indicate that he might have been subject to some form of monitoring to prevent self-harm while in police custody, but the information was not noted on the person escort record (PER) form which accompanied him from court and he was not identified as a risk. The PER noted that he was HIV positive.

2. At his reception health screening the man appeared physically well but said that he had been prescribed trazadone for depression for two years. Healthcare staff ensured that the man received appropriate medication for HIV and rebooked all outstanding hospital appointments for him. Throughout the reception process, nobody noted any indications that the man might be at risk of harming himself. Although he arrived with his medication for depression this was not re-prescribed as the doctor wanted this to be checked with his GP first. On 13 December, the man's GP confirmed that he had been prescribed lansoprazole for gastric problems and trazodone for depression. The medication was not re-prescribed but a medication review was booked for 27 December.

3. At the request of the police, the man and his two co-defendants were kept apart in the prison. On 22 December, the man explained to a chaplain that one of his co-defendants was his civil partner. He asked the chaplain to check on his partner for him. The man also wrote a note to his partner. There was nothing in the note that indicated any problems or that the man was having any thoughts about harming himself.

4. On 23 December, pharmacy staff noticed that the man's HIV medication would run out on Christmas Day. Healthcare staff contacted the hospital and arranged for an urgent prescription.

5. On 27 December, a doctor saw the man for his medication review. The computerised medical record system was not working that day and both the man and the doctor appeared to assume that the review was to consider his HIV medication. The doctor said that the man did not show any signs, of depression or distress. He asked for medication to counteract digestive disorder, a side effect of his HIV medication, which the doctor prescribed. Neither the doctor nor the man referred to his anti-depressant medication which had still not been prescribed. That afternoon, the man met his solicitor. After this, although he saw or spoke briefly with various staff on the wing in passing, the man had no significant contact with anyone else that day.

6. At approximately 5.20am on 28 December, a prison officer conducting a morning roll check saw the man hanging by a torn bed sheet in his cell. He called an emergency over the radio, but did not use the appropriate emergency code. The officer did not go into the cell, even when the healthcare staff arrived, but waited for the night orderly officer in charge of the prison. Healthcare staff examined the man, but it was apparent that he had

been dead for some time and resuscitation would not be possible. Paramedics arrived and agreed.

7. We are satisfied that the man generally received a good standard of healthcare at Durham, although we are concerned that his medication was not reviewed for more than two weeks after he arrived. We consider that it would have been difficult for staff to have foreseen and predicted the man's actions. Although it would not have altered the outcome for the man, who had apparently been dead for some time, we are concerned that there was a delay both in going into his cell and in calling an ambulance, either of which could be crucial in other circumstances. We make three recommendations about these matters.

THE INVESTIGATION PROCESS

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

9. The investigator obtained the man's relevant prison and medical records. He visited the prison on 14 January 2014 and spoke to the deputy governor, prison staff, prisoners who knew the man, and his partner, who was a prisoner at Durham.

10. NHS England commissioned Spectrum CIC to review the man's clinical care at the prison.

11. The investigator interviewed six members of prison staff and two prisoners. He and the clinical reviewer jointly interviewed members of the healthcare team. The clinical reviewer gave preliminary feedback on emerging findings to the Governor during the investigation.

12. We informed HM Coroner for Durham of our investigation and have sent him a copy of this report.

13. One of our family liaison officers informed the man's partner and nominated next of kin of the investigation. The investigator spoke to him to allow him to identify any specific issues he wanted the investigation to cover. He did not have any additional questions for the investigation. The man's partner received a copy of the draft report. He did not make any comments.

HMP DURHAM

14. HMP Durham is a local prison that serves the courts of Durham, Tyneside and Cumbria. It can hold approximately 1,000 men. Care UK provides primary healthcare services and Tees, Esk and Wear Valley NHS Trust provides mental health services.

Her Majesty's Inspectorate of Prisons

15. The most recent inspection report by HM Inspectorate of Prisons prior to the man's death was published in 2011. Inspectors found there were significant levels of self-harm, with over 250 incidents in the nine months before the inspection. Inspectors found that there was good strategic management of safer custody, but identified a need for improvements in suicide and self-harm prevention procedures. Although inspectors found that health services were satisfactory and clinical governance good, they were concerned that a change in prescribing practice had led to delays in prisoners receiving their medication. The Inspectorate have since published a further report

Independent Monitoring Board

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community to help ensure that prisoners are treated fairly and decently. In their annual report for the year to 31 October 2013, the IMB noted that Durham was a well-run and managed prison.

Previous deaths at Durham

17. Since 2011, including the man's, there have been five apparently self-inflicted deaths at Durham. Four of those who died had not been convicted and hanged themselves from the cell toilet doors. In recent reports, this office has made recommendations about the need for correct emergency codes to be used.

KEY EVENTS

18. The man was remanded to HMP Durham on 12 December 2013. He and his partner, and another man, had been charged with six separate sexual offences against children. He had previously spent time in prison, but not since 2002. The risk indicator section of the person escort record (PER) form that accompanied the man from court to prison noted that he had HIV. There was nothing to suggest he was regarded as a risk of suicide and self-harm.

19. When he arrived at Durham, a nurse carried out a reception health screen at which the man appeared physically well. He told the nurse that he had an outstanding appointment at the Royal Victoria Infirmary (RVI), Newcastle at the infectious diseases clinic with his HIV consultant. He did not have all his medication with him, including anti-retroviral medication, but also said that he had used trazodone (an anti-depressant and a sedative) for two years. The nurse referred him to a doctor.

20. The man saw a doctor that afternoon. He told her that he had been receiving treatment for HIV for over five years and was stable. However, he had not, taken his medication that day or the previous day and did not have any with him. The man also told the doctor that he was taking trazodone and lansoprazole (used to treat gastric problems, which can be a side-effect of anti-retroviral medication). The man had with him a pack of codeine and packs of trazodone tablets dated September, October and December. He said that he had been prescribed liquid trazodone and that had meant he had built up a supply of tablets. The doctor asked healthcare staff to contact the man's doctor for a medical summary and list of his prescribed medication before re-prescribing the medication. She also asked for a member of the healthcare team to contact the RVI urgently to confirm the man's HIV medication.

21. The man did not raise any concerns about his mental health during the reception process and there is no record that any members of staff were concerned about him. However, one of the police custody forms that arrived with him contained a copied page that indicated that he might have been subject to some form of monitoring in police custody because of a risk of self-harm. The five-page form was largely blank and did not have the man's name on it. The marking (a ring around the word "yes") was at the bottom of the second page and was very faint.

22. The next day, 13 December, a nurse telephoned the RVI to discuss the man's anti-retroviral medication, but the hospital was initially unable to confirm his medication. The nurse then telephoned the man's doctor's surgery and at their suggestion a local pharmacist and then a clinic in Newcastle. Eventually after speaking to someone else at the hospital, the nurse was finally able to establish the man's required HIV medication. The hospital arranged for a month's supply to be provided, and said that they would also arrange a review. (The hospital actually only sent 12 days' supply of medication.) The medication was given to the man that day.

23. Northumbria Police had asked that the man and his co-defendants be kept apart. The man stayed on the induction wing, F wing, while his co-defendants were held in other parts of the prison.

24. The man had an outstanding hospital appointment at the RVI. On 16 December a member of healthcare staff, contacted the hospital and explained that the man was now in prison. The hospital agreed to reschedule the appointment.

25. On 13 December, the prison received a letter from the man's doctor, which confirmed his medications (including trazodone). The letter was given to a prison GP, on 18 December. As the doctor had been concerned about the man having a stockpile of trazodone, the GP asked to see the man to discuss his medication. The appointment was made for 27 December. Later on 18 December, a nurse confirmed that the man had an appointment to see the HIV consultant at the RVI on 4 February 2014.

26. When interviewed, the GP said that he suspected that the man had not been taking trazodone as prescribed. He said that he could not see any record that the man had ever been prescribed trazodone in liquid form, which was the reason the man had given for having a large supply of trazodone tablets. The GP also said that the appointment had been delayed slightly because of Christmas. He acknowledged that this had extended the time between the man arriving at Durham and scheduling an appointment to discuss his medication.

27. On the afternoon of 18 December, the man saw the nurse for an HIV review. In preparation, she had contacted the HIV consultant's secretary at the Royal Victoria Infirmary for further information. The nurse subsequently asked the prison healthcare's administrative team to ensure that the man's outstanding appointment was arranged with the HIV consultant before his supply of medication ran out in mid-January. The man said that he had only missed his medication the previous Wednesday and Thursday, when he left police custody and arrived in prison. He said that he felt well, and was willing to go to his next hospital appointment escorted by prison officers.

28. After attending chapel on 22 December, the man spoke to the prison chaplain. He explained that he and the man's co - defendant, one of his co-defendants, were civil partners, that he was on F wing and the man's co - defendant was on C wing, and asked the chaplain if he could check on the man's co - defendant's wellbeing and tell him that he was thinking of him. The chaplain told the investigator that he saw the man's co - defendant either later that day or on 23 December.

29. The man then wrote to the man's co - defendant. He commiserated with him for not getting bail, said that he missed him, and that he had spoken to the chaplain and officers on the wing to try to arrange a move to the man's co - defendant's wing. There was nothing in the note that indicated any problems or that the man was having any thoughts about harming himself. The man's

co - defendant told the investigator that the letter gave him no cause for concern.

30. On 23 December, pharmacy staff noticed the shortfall in medication and told the nurse that the man would run out of HIV medication on Christmas Day. The nurse telephoned the RVI and requested an urgent prescription to bridge the gap until his appointment in January. Prison pharmacy staff collected the medication the next day, 24 December. There is nothing in the man's record to indicate how he spent Christmas Day or Boxing Day or that there was anything significant to report.

31. On the morning of 27 December, the man attended his scheduled appointment with the GP to review his medication. That morning, the healthcare computer system was not working and the GP was unable to read the medical histories for his list of appointments. He decided to see the prisoners who attended, which would allow him to address any serious issues and update the computer system when it was back online. The consultation with the man was brief and focused on his HIV medication. The GP told the investigator that the man did not mention that he had not been receiving trazodone. The GP noted that the man was not disturbed or distressed, and did not express any feelings of depression. He did not complain about his medication other than to mention that he had missed his prescriptions for two days after he arrived in prison while his medication was confirmed.

32. That afternoon, the man met his solicitor. During the meeting, his solicitor told the man that Northumbria Police were considering bringing further charges against him. The solicitor told the investigator that the man did not seem unduly upset by this, although he said he was concerned about the man's co - defendant. He asked how long a sentence he might expect to receive, but his solicitor said he could not say until he knew whether there would be further charges and what they were. After this meeting, the man spoke briefly with various members of staff in passing, but did not have any significant contact with anyone else that day.

33. The prisoner in the cell opposite the man told the investigator that, as far as he was aware, the man did not have any problems with other prisoners and had no issues such as bullying or debt. The other prisoner had previously worked as a prison induction unit orderly, and said that he was used to identifying signs of distress in prisoners. He did not see any in the man. He saw the man return from his legal visit that afternoon, but they did not speak before they were locked into their cells for the night.

34. The man was in cell 12 on the third landing of F wing, which is a single cell at the end of the corridor. He was not subject to any special monitoring, so after being locked into his cell, staff saw him only at standard roll checks. There are two mandatory roll checks, one when the night staff come on duty, the other just before the morning staff take over. The officer carried out the late evening roll check between 8.30pm and 9.00pm. He did not notice anything out of the ordinary when he checked the man's cell.

35. There is nothing in the wing observation book to indicate that the man sought staff attention after being locked into his cell that evening and the wing does not have electronic cell bell records. The other prisoner said he did not recall anything untoward happening during the night, and the officer did not have any reason to check on the man. Night staff usually have to log into electronic pegging points around the wing to show that they have patrolled a minimum number of times. That night, there were a higher than usual number of prisoners being managed under suicide and self-harm prevention procedures on F wing who required frequent monitoring so the night orderly officer agreed that the officer did not have to peg as frequently as usual. He said that he still carried out patrols of the wing during the night, but nothing drew his attention to the man's cell.

36. At approximately 5.00am, the officer began the morning roll check and said he reached the man's cell at approximately 5.30am. He opened the observation panel in the cell door, put the cell light on and saw the man hanging by a bed sheet from the toilet door. He radioed an urgent call across the network (recorded as 5.29am on the incident log), saying that someone had hanged himself using a ligature. He gave the location, but did not use an emergency code. He then went to the corner of the spur so that staff coming onto the wing could see where he was.

37. An officer was in the emergency control room (ECR), when he heard the officer's radio message and called an ambulance. The ambulance service, however, said that they would not send an ambulance unless the officer first provided the patient's name and further details. The officer began to look up the occupant of the cell on the computer.

38. A nurse and a healthcare support worker, were on I wing, adjacent to F wing, when they heard the officer's radio message. They collected the emergency bag, a defibrillator and oxygen, and joined the officer outside the man's cell. The nurse said she looked through the cell observation panel and saw the man hanging. He was motionless and, from his appearance, the nurse formed the impression that he was dead.

39. The night orderly officer had heard the officer's radio message and immediately went to F wing, where she found the officer, nurse and the healthcare support worker waiting outside. The night orderly officer opened the cell door and went in with two officers who had also responded to the radio message. The man had made a loop from a torn bed sheet and wedged one end between the door and door frame of his cell toilet. The night orderly officer and the officer lifted the man while the officer used an anti-ligature knife to cut the sheet, and they lowered the man onto the bed. They then left the cell to allow the healthcare staff space to attend to the man. The night orderly officer telephoned the emergency control room to advise them of the situation and to request an ambulance. The officer said that he had already done so, but first needed the prisoner's name, which he was looking up on the computer system. The night orderly officer gave him the information, and the officer then telephoned the ambulance service again and asked for an emergency ambulance. (The incident log shows an ambulance was called at

5.33am, but it is not clear whether this was the first or the second call.) The ambulance arrived at the gate at 5.36am.

40. The nurse and the healthcare support worker checked the man for signs of life. He was not breathing, had no pulse, was cold to the touch, and appeared to have been dead for some time. They applied the defibrillator. At this point, the designated emergency response nurse in the prison that night, joined them. The defibrillator detected no rhythm in the man's heart. When interviewed, the nurse said that rigor mortis had set in. The nurses and the healthcare support worker agreed that there was nothing that could be done for the man, and resuscitation would not be appropriate.

41. At approximately 5.40am, the ambulance crew arrived at the cell and checked the man, and also detected no signs of life. At 5.43am, they declared that the man had died.

Debrief

42. A hot debrief was held later that morning. The staff care team attended and offered support. The debrief identified that the officer had not used an emergency code blue signal when he found the man hanging.

Contacting next of kin

43. The chaplain, a trained family liaison officer, was contacted and came to the prison and was briefed about what had happened. The man had nominated his partner and co - defendant, as his next of kin so the chaplain and a colleague went to see him and broke the news. The man's partner was closely monitored under suicide and self-harm prevention procedures and supported.

Informing prisoners

44. Notices were posted informing other prisoners of the man's death and offering support. The man's other co-defendant, was supported by the mental health in-reach team. All other prisoners subject to suicide and self-harm prevention procedures were reviewed in case they had been adversely affected by the man's death.

45. The man had left a note to his partner which just said "I love you [name of partner]". The night orderly officer ensured that staff checked on the man's partner's wellbeing.

Funeral

46. The chaplain conducted the man's funeral. In line with guidance, the prison contributed to the costs.

ISSUES

Clinical care

47. The clinical reviewer found that the man received healthcare of an equivalent standard to that which he could have expected in the community. She considered that there was some excellent practice in some aspects of his care such as ensuring that he obtained his HIV medication as quickly as possible when he arrived at Durham. An outstanding hospital appointment was rearranged, and pharmacy staff made sure that the man did not run out of medication over the Christmas period.

48. At the reception health screen, the nurse referred the man to a GP because he had arrived at prison with a large amount of an antidepressant, trazodone. A GP asked for his community GP records to be checked to see if he had been prescribed trazodone and another GP arranged to see the man to discuss his medication on 27 December. Neither doctor was happy with the man's explanation for having so much trazodone, and the GP could not find any record that the man had been issued trazodone in liquid form as he had claimed. However, the computer system was not working at the appointment and the GP therefore did not have his notes to show that he wanted to discuss the trazodone. The man did not mention trazodone, but did ask for something to counter the effects of his other medication. There were no other indications that he had depression or any mental health issues. When the computer system was back working, the GP did not rebook the appointment to discuss trazodone or investigate whether he was still suffering from depression. While this should have been done, the clinical reviewer did not believe that it would have been a factor in the man's death as his stock of medication indicated that he had not been taking trazodone for some time when he arrived.

49. However, we are concerned that the man's medication was not reviewed with him for over two weeks after he arrived in prison. His community GP records were faxed to Durham on 13 December. He was not given the medication his community GP had prescribed, yet a medication review was not scheduled until 27 December. It is important that such medication issues are resolved as quickly as possible after a prison arrives and we make the following recommendation:

    The Head of Healthcare should ensure that medication reviews are held promptly for newly-arrived prisoners to resolve any issues when they are not given medication in line with their community GPs' prescription.

50. The clinical reviewer noted that when the man was found hanging, it was apparent that he had been dead for some hours. We are satisfied that it was reasonable not to attempt to resuscitate him.

Risk of self-harm

51. When the man arrived at Durham, the PER did not include any warnings and there was little to suggest that he was at risk of suicide and self-harm. While there was some indication that the man might have been regarded as at risk of self-harm when he was in police custody, this was not clearly indicated to anyone and there is no reason to believe, had they been aware of this information, that prison staff would have assessed him as being at risk of suicide and self-harm. During reception, during his health screening and during consultations with doctors he gave no indication that he had any intentions of harming himself and there were few counterbalancing static risk factors to suggest that the man was at risk. When he wrote to his partner, there was no sign that he was in any distress. We are satisfied that it would have been very difficult for staff at the prison to have anticipated his actions.

Entering the man's cell

52. National guidance for entering cells at night is given in Prison Service Instruction (PSI) 24/2011. The PSI says that under normal circumstances authority to unlock a cell at night must be given by the night orderly officer and a cell opened with a minimum number of staff (according to local risk guidelines) present. However, the PSI goes on to say, that the preservation of life must take precedence over this and where there is or appears to be threat to life, cells may be opened without the night orderly officer present and entered by staff on their own if they feel safe to do so, having performed a dynamic risk assessment and informed the control room. The local instructions at Durham reflect this.

53. The officer did not go into the cell when he saw the man hanging, or when healthcare staff arrived although he had a cell key in a sealed pouch for use in an emergency. Instead, he waited for the night orderly officer to arrive and open the door. It is appropriate under the guidance that staff do not enter cells if they have completed a dynamic risk assessment and they do not feel that it is safe for them to do so. However, the officer told the investigator that he would not open a cell door in any circumstances if he was on his own. This also delayed heathcare staff attending to him. Although it is apparent that the man was already dead when the officer found him, the officer was unaware of this at the time. It is a concern that the officer would not consider going into a cell in any circumstances as, in other situations, a delay could mean the difference between life and death. All members of staff should be prepared to go into cells when there is a risk to life unless there is a clear threat to their safety. We make the following recommendation:

The Governor should ensure that all staff understand that, subject to a personal risk assessment, they should enter a cell at night when there is a potential risk to life and that local policies and instructions reflect this prominently.

Use of emergency codes

54. Prison Service Instruction 03/2013 requires governors to have a two code medical emergency response system based on the instruction. As is usual, Durham use code blue to indicate an emergency when a prisoner is unconscious, or having breathing difficulties, and code red when a prisoner is bleeding. Calling an emergency code should automatically trigger the control room to call an ambulance.

55. When the officer found the man hanging, he called an emergency over the radio network and said that it involved a ligature. When interviewed he said that he was aware that, according to the protocol, he should have used code blue, but decided that using the words "urgent" and "ligature" would ensure the appropriate response. The night orderly officer and nurse both told the investigator that it was helpful to know that a ligature was involved, because a code blue call can cover different scenarios.

56. The officer was the prison officer working in the emergency control room that morning. Even though an emergency code blue was not used, the officer telephoned for an ambulance immediately. There was therefore no delay caused by the other officer not using the recognised emergency code. However, in another situation, involving different staff, not using the emergency code might not lead to such an effective response. Three recent investigation reports into deaths at Durham have referred to the issue of ensuring an appropriate emergency response and it is concerning that we have to raise it again.

57. When the officer telephoned the ambulance service to request an emergency ambulance, he was told that they would not despatch one unless they knew the name of the prisoner. This has potentially serious implications, particularly during the night when staffing levels are lower and information less easily available. PSI 03/2013 includes a mandatory instruction that the terms of the medical emergency response protocols must be written and agreed in conjunction with the local healthcare commissioner at the prison and the local ambulance trust. We consider that the Governor should discuss this with the local ambulance trust and ensure that all staff are clear what information is needed when an emergency ambulance is called and that the ambulance service understands that in the prison context the person calling an ambulance might not necessarily have details of the prisoner involved. In response to our preliminary findings from this investigation, the Governor told us that he had asked a senior member of staff to look at this issue. We make the following recommendation:

The Governor should ensure that all prison staff are reminded of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Durham has a protocol agreed with the local ambulance service which ensures they understand the prison context and that staff who request ambulances might not have immediate detailed information about the patient.

Ligature points

58. We have investigated the deaths of four other prisoners who had hanged themselves in Durham and who had used the toilet doors to support the end of a ligature. In response to this, the prison shortened all cell toilet doors so that ligatures could not be secured at the top between the door and the frame.

59. The man had wedged the end of a bed sheet between the door and the frame at the side, above the hinge. As the man was not being managed under suicide and self-harm prevention procedures, and had not given any indication that he was at risk of harming himself, there was no reason for him to be located in what is known as a safer cell, with reduced ligature points. Standard prison cells at Durham contain a number of other ligature points and we do not consider that it would be feasible to provide cells which are entirely ligature free.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that medication reviews are held promptly for newly-arrived prisoners to resolve any issues when they are not given medication in line with their community GPs' prescription.

2. The Governor should ensure that all staff understand that, subject to a personal risk assessment, they should enter a cell at night when there is a potential risk to life and that local policies and instructions reflect this prominently.

3. The Governor should ensure that all prison staff are reminded of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Durham has a protocol agreed with the local ambulance service which ensures they understand the prison context and that staff who request ambulances might not have immediate detailed information about the patient.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that medication reviews are held promptly for newly-arrived prisoners to resolve any issues when they are not given medication in line with their community GPs' prescription	Accepted	During the healthcare assessment a note is made of all medication that the newly-arrived prisoner was prescribed in the community. A GP conducts a medication review to decide whether to continue or change the prescription. Any changes are communicated to the patient. Patients who would like further explanation or a review of the decision are able to request an appointment with a GP. The target waiting time for GP appointments is 3-5 days, and performance against this is monitored monthly.	Head of Healthcare 31/10/2014	
2	The Governor should ensure that all staff understand that, subject to a personal risk assessment, they should enter a cell at night when there is a potential risk to life and that local policies and instructions reflect this prominently.	Accepted	A Notice to staff (NTS) has been issued to remind staff that they should enter a cell at night when there is potential risk to life. The LSS already reflects this policy.	Head of Residence and Safety 30/06/2014	Completed 23/06/2014
3	The Governor should ensure that all prison staff are reminded of and understand PSI 03/2013 and their responsibilities during medical	Accepted	A NTS will has been issued reminding staff of the need to adhere to PSI 03/2013 during medical emergencies.	Head of Residence and Safety 30/06/2014	Completed 23/06/2014

	emergencies and that Durham has a protocol agreed with the local ambulance service which ensures they understand the prison context and that staff who request ambulances might not have immediate detailed information about the patient.		The ambulance protocol between the prison and ambulance service will be revisited to ensure that ambulances will be despatched to the establishment even in the case that the caller may not have all of the immediate information about the patient.	Head of Operations 30/09/2014	