



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man in April 2014,
while a prisoner at HMP & YOI Parc**

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 at HMP Parc in April 2014. He died in hospital the next day. He was 36 years old. I offer my condolences to his family and friends.

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

The man had been released on licence from a five year prison sentence in March 2013 but was recalled to HMP Swansea on 14 November 2013 after he breached his licence conditions. He received medication for mental health problems and methadone to treat addiction to heroin. On 31 January 2014, he transferred to HMP Parc where a GP changed his antidepressant medication. The man did not always take his medication as prescribed.

The man appeared to settle well at Parc and he had close family and friends living on the same unit. No one had any concerns that he was not coping, until the afternoon of 2 April, when he told a prison chaplain that he felt suicidal. The chaplain began Prison Service suicide and self-harm prevention procedures but a unit manager did not discuss with the man the measures he would need to keep him safe pending a full assessment which happened the next day. He did not consider that he should share a cell or make clear that he intended that he should be observed twice an hour. Later that evening, an officer found him hanging. Paramedics took him to hospital, where he eventually died.

Healthcare Inspectorate Wales was satisfied that many aspects of the man's clinical care at Parc were of a good standard, but identified a need for more effective checks when prisoners do not take their medication as directed. While there was little to indicate to staff that the man was at imminent and very serious risk of suicide, I am concerned that staff did not follow required suicide and self-harm procedures, designed to protect prisoners at risk.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

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SUMMARY

1. The man had been released from prison in March 2013, but was recalled to HMP Swansea on 14 November 2013, for breaching his licence conditions. He transferred to HMP Parc on 31 January 2014. When he arrived, he told reception staff that he had no current thoughts of suicide and self-harm but had attempted to hang himself ten years before. He said that he had mental health problems, including personality disorder and depression. He took various medications, including an antipsychotic, an antidepressant and methadone for heroin addiction. A prison GP changed the man's usual antidepressant medication to an alternative, which the GP considered more suitable.
2. On 14 February, the man moved to B3 unit at Parc, a specialist unit for prisoners with drug and alcohol problems. His brother, cousin, nephew and a close friend also lived on this unit. He seemed to settle at Parc, but did not always take his medication as prescribed. A doctor stopped the man's antipsychotic prescription after he did not collect it for a time, but no one discussed this with him.
3. On the afternoon of 2 April, the man told a prison chaplain that he was not getting the correct medication and said he was hearing voices and having suicidal thoughts. The chaplain began Prison Service suicide and self-harm prevention procedures, known as ACCT. An evening association period started soon after this, and the man spent the next two hours with his family and friends on the unit. No one had any concerns about him. At 7.00pm, officers locked all prisoners in their cells for the night. He was alone in his cell, as his cellmate had been moved to the segregation unit, two days earlier.
4. A unit manager decided that staff should check the man twice an hour until his initial ACCT assessment and review the next day. He did not mark this on the front of the ACCT document and officers monitored him only once an hour. At 9.25pm, an officer found the man hanging in his cell. Officers quickly started to try to resuscitate him and nurse and paramedics took over when they arrived. Paramedics gave him adrenaline and detected a pulse. They took him to hospital, but he later died.
5. Although prison staff had identified the man as a risk of suicide and self-harm, ACCT processes designed to protect prisoners at risk until a full assessment and review, did not operate effectively. We understand that there were few signs that the man was at imminent and immediate risk of killing himself, but the unit manager did not speak to the man before deciding that he could remain alone in his cell, as he should have done. Instead, he relied on previous knowledge of the man. He did not record properly that staff should observe him twice an hour. Although it did not delay the emergency response, the first officer on scene used the wrong emergency code. We make three recommendations about these matters. The clinical review found that the general standard of healthcare that the man received was better than he could have expected in the community although some aspects of medication management were poor.

THE INVESTIGATION PROCESS

6. We issued notices to staff and prisoners at HMP Parc, informing them of the investigation and inviting them to contact the investigator, if they had relevant information. One prisoner responded.
7. The investigator obtained copies of the man's prison and healthcare records. He interviewed 16 members of staff and three prisoners at Parc and interviewed the man's brother at HMP Swansea.
8. The investigator informed HM Coroner for Bridgend and Glamorgan Valleys District of the investigation and we have sent him a copy of this report.
9. Healthcare Inspectorate Wales reviewed the man's clinical care at HMP Parc.
10. One of the Ombudsman's family liaison officers wrote to the man's father and one of his brothers to inform them of the investigation and offer them the opportunity to identify concerns. They did not respond with any specific issues for the investigation to consider. Another of the man's brother's, who was in Parc at the same time, was concerned that that his brother had not been prescribed the correct medication for his mental health problems.
11. The family received a copy of the draft report and indicated they were content that the report was accurate.

HMP PARC

12. HMP & YOI Parc opened in 1997 and is run by G4S Care and Justice Services on behalf of the Prison Service. HMP Parc had major additions and alterations in 2010. These changes included a new wing for 400 prisoners, a vulnerable prisoner area and a new healthcare facility. Parc's operational capacity at the end of July 2013 was 1336. It is currently expanding further.

HM Inspectorate of Prisons

13. The most recent inspection of HMP Parc was in July 2013. Inspectors found that Parc delivered good or reasonably good outcomes in every area inspected. Most prisoners reported feeling safe. Inspectors found that care for prisoners at risk of suicide and self-harm had improved since the previous inspection. Eighty per cent of prisoners said that staff treated them with respect and Inspectors observed good interactions and a culture of mutual respect. The quality of ACCT documents was good with detailed support plans prepared in consultation with the prisoner.

Independent Monitoring Board

14. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure that prisoners are treated fairly and decently. In its most recently published report for the year to February 2013, the IMB noted that there had been problems earlier in the year where staff had not always completed required elements of the ACCT process had management checks had not picked this up.

Previous deaths at HMP Parc

15. The man's was the fifth apparent self-inflicted death at Parc since this office began investigating deaths in prisons in 2004 and only the second since August 2008. The investigation into the last death, which occurred in 2010, also discovered flaws in the operation of ACCT processes.

KEY EVENTS

16. On 28 June 2010, the courts remanded the man to HMP Cardiff and later convicted him of wounding with intent to cause grievous bodily harm. The judge sentenced him to five years and three months imprisonment.
17. On 22 March 2013, the man left prison on licence but returned to HMP Swansea on 14 November after breaching his licence conditions. His sentence end date was 21 November 2016.
18. On 31 January 2014, the man transferred from Swansea to HMP Parc. A nurse assessed him when he arrived and noted that he had mental health diagnoses of personality disorder, post-traumatic stress disorder and depression. The man disclosed that he had attempted to hang himself ten years earlier, but said he had no current thoughts of self-harm. The nurse recorded the man's prescriptions of methadone (a synthetic opiate used to treat heroin dependency), mirtazipine (an antidepressant), olanzapine (an antipsychotic) and gabapentin (for pain relief). He moved to a cell in the induction unit.
19. On 12 February, a doctor reviewed the man and noted that he had a diagnosis of minor drug-induced psychosis, with elements of antisocial personality disorder as well as a mixed anxiety and depressive disorder. The doctor re-prescribed olanzapine, which he thought would be helpful to reduce impulsivity. The man agreed to try citalopram, an alternative antidepressant to mirtazipine. The doctor later explained that mirtazipine interacted poorly with some other drugs, including methadone, and said that prisoners often traded mirtazipine.
20. On 14 February, a note in the man's clinical records stated his dose of methadone was 40 millilitres each day for the next eight weeks. He would then begin a standard detoxification plan (where the daily methadone dose gradually reduces to zero). That day, the man moved to a shared cell on B3 unit (for prisoners with drug and alcohol problems). The man's brother, nephew, a cousin and a close friend also lived on the unit. Another prisoner helped the man with numeracy and literacy difficulties, through the Toe by Toe programme.
21. On 28 February, a nurse saw the man for an initial mental health assessment. She referred him to the mental health team and became his primary nurse. She said that the man's main concern that day was whether he would continue to receive methadone.
22. On 4 March, the man told an officer, who had met him soon after he had arrived at Parc, that he had been in and out of prison for years so he knew many of the other prisoners and was happy enough. The officer noted in the man's record that he had settled well, had caused no issues and abided by the prison rules and regimes.
23. The man had stopped taking citalopram by the end of February as he said it made him feel worse. On 10 March, a doctor prescribed an alternative

antidepressant, sertraline. The man kept up to a week's supply of sertraline in his possession.

24. On 26 March, a nurse reviewed the man's mental state and noted a marked improvement since when she had last seen him. However, he told her that he had been buying mirtazapine from other prisoners. Her plan was for him to see a psychiatrist about his reported post-traumatic stress disorder and personality disorder. She was unsure how long it would take to see a psychiatrist, but as his case was not urgent, estimated it would have been around a month.
25. On 27 March, a doctor cancelled the man's olanzapine prescription as he had not been collecting it for some time. There were several entries in his medical records about him not attending medication reviews, but there is no record that anyone spoke to him about this or asked him why had not been taking it.
26. On 29 March, the man's daily methadone dose reduced from 40mm to 35mm as part of the detoxification plan. On 31 March, staff moved his cellmate to the segregation unit, leaving the man alone in the cell.
27. At 6.45pm on 1 April, the man telephoned a friend to ask him to write a statement for his next parole hearing, which was due later in the month. He said that he understood from his probation officer who had visited him earlier that day, that he had a good chance of parole. He said that his probation officer had told him that even if he was unsuccessful at his next parole hearing, he should be out of prison before Christmas. (This was the last of four telephone calls the man made between 19 March and 1 April. The investigator listened to recordings of the four calls and the man did not say he felt low or depressed and he appeared positive.)
28. The man's brother told the investigator that his brother had mental health problems. When he came to Parc they had changed his prescription from mirtazapine to citalopram, but he stopped taking it because of side effects. He said that one day his brother had gone to the medicines hatch to collect his olanzapine, but there was none for him. The same thing had happened the next day and a nurse told him that they would sort out the problem. (It does not appear that anyone had told the man that the doctor had cancelled the prescription for olanzapine because he had not been collecting it for some time.)
29. The investigator spoke to three officers who said that they had known the man well. One officer said that he had known a lot of the other prisoners and she described him as a "coper". She said there was nothing that had caused her to worry about his safety. The other two officers had similar views about him. Another officer said that the man was the sort of person who would ask staff if he needed help.
30. A substance misuse worker at Parc at the time said she had known the man from previous sentences, and had bumped into him on the morning of 2 April. He had asked her for help with his methadone detoxification but did not mention any problems with other medication. She said she had told him that

she would be in the substance misuse clinic on 4 April and he could see her and a doctor to discuss his medication. He agreed, and she booked an appointment. She was not aware that the man had not been taking some of his prescribed medication, but said that the appointment would have included a review of all his medication and his compliance with taking them. She said that there had been nothing out of the ordinary about their conversation.

31. A Roman Catholic chaplain at Parc told the investigator that he had gone to B3 unit on the afternoon of 2 April to pass a message to the man's brother. Their mother was terminally ill and had been in hospital and he had discovered that she was now at home. As they were speaking to him, the man had asked to talk to him. He said that he knew the brother, but this was the first time he had met the man.
32. The chaplain and the man sat together at a table and the man told him that he had a personality disorder, that he was hearing voices and that he was not receiving the right medication. The chaplain told him that he would need to speak to someone from the healthcare team about this. The man said that he was having suicidal thoughts. The chaplain told the investigator that he seemed more angry about his medication, rather than suicidal, but he opened an ACCT document and asked the first landing officer to help him. The chaplain noted on the ACCT plan that the man was concerned about his medication and had suicidal thoughts.
33. The first landing officer confirmed that she had helped the chaplain open the ACCT document. She said that other officers were in the wing office at the time and, as a team, they had thought that staff should check the man once an hour. The chaplain entered the frequency of observations on the front of the ACCT document.
34. After an ACCT has been opened, the next part of the process is for a manager to complete an immediate action plan to help keep the prisoner safe until the first case review. The instructions say that the manager should talk to the prisoner as a first step towards completing the plan. The unit manager who completed the man's immediate action said that he did not work on B3 but the officer and chaplain had asked him to come to complete the man's immediate action plan. He said that he knew him from a previous sentence and knew that he preferred a single cell unless he knew the other person. The unit manager did not consider that he needed to speak to the man before completing the plan and decided that he could remain alone in his cell. The unit manager noted on the immediate action plan that staff should observe him twice each hour. He did not enter this on the front of the ACCT document so the previous entry remained, indicating observations at once an hour.
35. When interviewed, the unit manager acknowledged that he should have spoken to the man before completing the immediate action plan. He acknowledged that he had not written the frequency of ACCT observations on the front of the ACCT document, but did not recall that there had been any other entry on the front about the frequency of observations.

36. The B3 houseblock manager was on leave on 2 April. She told the investigator that when the man had arrived on the unit he was reluctant to share a cell but was prepared to share with someone he knew. She allocated him a cell with someone from his home area and he was happy with this. When the other prisoner went to the segregation unit on 31 March, this left the man alone in the cell. She said that when the staff opened the ACCT, they should have found him a suitable cellmate. If he had refused to share then they should have recorded this.
37. After the unit manager had completed the immediate action plan, the first landing officer took it to the man to sign to allow staff to share relevant information. She told him that there would be a multidisciplinary review the next day, which would include healthcare staff and managers. He would then be able to speak to people who could help sort his problems. She noted in the ACCT plan that he was also troubled because his mother was very ill and that it was the anniversary of the death of one of his brothers. He told her that he was more frustrated than anything else. He said that watching television irritated him so much that he was worried that he would either throw it at someone or throw it off the landing. He asked her to take it out of his cell, which she did.
38. The first landing officer said that during the evening association period from 5.00pm to 7.00pm, the man spent the evening with his brother, cousin, nephew and a friend and they played pool. She thought the man had made a telephone call. His records do not show that he made a call at this time but it is possible that he joined in a call with one of his family. She said that, as usual, the group associated together happily.
39. The man's cousin told the investigator that everything had seemed as usual that evening, but just before officers locked them up, he had hugged his nephew and told him that he loved him. The cousin said that this was unusual for the man, but he had not thought much more about it at the time. The cousin lent the man his CD player so that he could listen to some music, as he had asked staff to remove his television.
40. One of the man's friends told the investigator that he thought he had seemed fine that evening. The man's brother said that at lock-up time, his brother had said, "See you in the morning".
41. An officer recorded checks in the man's ACCT document that evening. He told the investigator that nothing out of the ordinary had happened to cause him any concern. When he locked his cell at 7.00pm, he had said that he felt a lot better.
42. The last time the first landing officer saw the man was at 7.55pm just before the end of her shift. At the time, he was sitting on his bed writing.
43. The second landing officer came on duty at just after 8.00pm. The first landing officer handed over to her and told her that staff had opened an ACCT for the man. The second landing officer did a roll check at 8.30pm and noted that the man was sitting on his bed listening to music.

44. The second landing officer checked the man again at about 9.25pm. She said that when she first looked into his cell, she could not see him. She then saw his head to the right of the door about a metre from the ground. She realised that something serious had happened and radioed a code red emergency. (She explained that Parc had until recently used code red for all emergencies but now follows the national protocol and has a two code system with code red to indicate loss of blood and code blue to indicate a prisoner unconscious, hanging or with significant breathing problems. She said that, in her panic, she had used the wrong code.) She said that as soon as the control room operator had announced the emergency across the radio network she asked him to release the door. (At Parc, the control room can unlock cells remotely.)
45. Another officer was carrying out security checks just outside B3 unit when he heard the emergency call. He ran to the cell and, as he arrived, the second landing officer was opening the cell door after the control room had released the lock. He said he went into the cell and saw the man hanging by a belt attached to the toilet door. He lifted the man and, as he did, the belt came away from the door. He and the second landing officer lowered the man to the floor. The belt was tight around the man's neck but he forced his fingers between the belt and the neck and it came away.
46. The officers examined the man and found he was not breathing and had no pulse. They began cardiopulmonary resuscitation and took turns giving chest compressions. Nurses arrived four minutes later.
47. One of three nurses who responded told the investigator that after the code red call, the night orderly officer (the person in operational charge of the prison) announced over the radio that officers were starting cardiopulmonary resuscitation so she was aware that they were dealing with someone who was not breathing. She and the two other nurses collected full emergency equipment, including oxygen and a defibrillator (a life-saving device that gives the heart an electric shock in some cases of cardiac arrest) and went to B3. They checked the man with the defibrillator several times. Each time it advised that they should not give a shock and they continued giving oxygen and chest compressions. Paramedics arrived at 9.45am and gave him adrenaline (used to treat cardiac arrest). They then detected a pulse.
48. Paramedics took the man to hospital, where he arrived at about 10.20pm. The hospital admitted him to the intensive care unit. The prison contacted a prison chaplain and family liaison officer and she arranged with the Catholic chaplain that she would go to the hospital and he would go to Parc to keep the man's brother informed. (He knew that his brother had been taken to hospital after an emergency.) The chaplain arrived at the hospital at 10.50pm. A doctor told her that the man was likely to die and she began trying to telephone his sister. Parc arranged to bring the man's brother from the prison to the hospital and contacted his sister at around midnight. The family were at his bedside when hospital doctors removed life support. He died 30 minutes later. Parc contributed to the funeral costs in line with national guidance.

49. A post-mortem examination found that the man's cause of death was cerebral hypoxia secondary to asphyxia due to hanging. Cerebral hypoxia is a condition where there is a decrease in oxygen supply to the brain even though there is adequate blood flow. Brain cells can begin to die within five minutes after loss of oxygen supply. This can lead to coma and brain death even though cardiovascular function is preserved.

ISSUES

Clinical care

50. Health Inspectorate Wales (HIW) found that the man did not present with symptoms of serious depression while he was at Parc. Although HIW found that mental health referral processes were not systematic and were confusing, a nurse had referred him to a psychiatrist on 26 March, to investigate his reported post-traumatic stress disorder and personality disorder. The nurse did not regard this as an urgent referral, which meant that a psychiatrist would have seen him around a month later. We are satisfied this was reasonable.
51. HIW found that the man's general standard of care at Parc was in some ways better than that which he could have expected to receive in the community. In particular, they found that he had good access to healthcare professionals who offered him support. He also had a well-structured detoxification programme. However, HIW found no evidence of a proper assessment of his suitability to hold sertraline in his possession and healthcare staff did not check that he took the sertraline as prescribed.
52. HIW noted that the man frequently refused to take or did not attend to collect his olanzapine and citalopram. Nurses did not escalate his poor compliance with taking his medication to the mental health team or follow this up systematically. The man did not turn up for medication reviews when requested, but no one appears to have sought him out to discuss why he was not taking his medication. When he stopped collecting olanzapine during March, the doctor made a reasonable decision to cancel the prescription, but no one appears to have explained this to him. Prisoners, just like patients in the community, are able to decide whether to accept or comply with treatment. However, we consider that healthcare staff at the prison should have made more active efforts discuss with him his evident problems with his medication. We make the following recommendations:

The Head of Healthcare should ensure that there are effective procedures to monitor prisoners' compliance with their medication and that nurses responsible for coordinating mental health care follow up missed medication as part of an active care plan approach.

ACCT procedures

53. After the chaplain opened the ACCT document, the unit manager completed the next part of the process, the immediate action plan. The purpose of such a plan is to keep the prisoner safe until the next part of the process- an assessment and first case review. This would have happened the next day.
54. Two key aspects of the immediate action plan are to identify where the prisoner should be located and how often staff should support and observe them. The guidance on the ACCT document states that the manager responsible should make their decisions, after consulting the prisoner. It says that they should particularly consider whether they should share a cell with another prisoner.

55. The unit manager told the investigator that he knew the man and that usually he preferred not to share a cell. He did not speak to the man about his immediate needs and decided to leave him alone in his cell, based on his past knowledge. However, the chaplain had just opened an ACCT because he believed that the man was at risk of suicide or self-harm. Taking into account past knowledge in such circumstances is dangerous. Other staff also said that the man not to share unless he knew the other prisoner. There were other prisoners on B3 unit who the man knew well, and we consider that the unit manager should have discussed with him the possibility of sharing a cell. While some prisoners take their lives in a shared cell, sharing a cell is usually a protective factor. The man might well have been deterred from his action had he been sharing that night.
56. When he completed the immediate action plan, the unit manager noted that staff should observe the man twice an hour. He did not note this on the front of the ACCT document, which instead showed that the man was on hourly observations. He said that he did not think that there was any entry on the front about frequency of observations, but he should have completed this, whether or not there were any other entries, to make it clear to the staff what he expected.
57. Parc identified these irregularities in the ACCT procedures soon after the man's death and conducted its own investigation. As a result, the unit manager was subject to disciplinary procedures. We therefore make no further recommendation in respect of these actions.
58. We accept that there was little to indicate that the man was at imminent risk of suicide. None of his family and friends who he spent time with earlier in the evening had any concerns about him and it had been many years since he had previously attempted suicide. However, it is important that required ACCT procedures are followed to help ensure prisoners' safety. We cannot know whether these procedural deficiencies would have affected the outcome for him. We make the following recommendation:

The Director 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:

- **Consulting prisoners to help determine what will help to keep them safe**
- **Completing all necessary ACCT documentation fully and accurately**

Emergency codes

59. Prison Service Instruction (PSI) 3/2013 Medical Emergency Response Codes, issued in February 2013, sets out the actions staff should take in a medical emergency. It contains mandatory instructions for prisons to communicate the nature of a medical emergency efficiently using a two level code system to differentiate between a blood injury and all other injuries. It recommended that

prisons should use code red for blood or burns and code blue for breathing and collapses to help ensure that staff take the appropriate emergency equipment to the incident. The control should call an ambulance immediately staff call an emergency code. The PSI states that all prison staff should be made aware of and understand the instruction and their responsibilities during medical emergencies.

60. Parc had changed its systems to comply with the PSI but when the second landing officer discovered the man hanging she announced a code red emergency. She told the investigator that she knew the correct process but in a panic had used Parc's previous coding of red (when a code red was used for all forms of emergency). The code red call was quickly followed by a message that officers had or were about to commence cardiopulmonary resuscitation and the nurses took all appropriate equipment. The control room called an ambulance immediately. Although there was no adverse outcome, it is evident from this (and a subsequent death at the prison) that the system is not yet embedded at Parc. We make the following recommendation:

The Director should ensure that, in line with PSI 03/2013, all staff fully understand and follow the protocol for emergency medical codes.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that there are effective procedures to monitor prisoners' compliance with their medication and that nurses responsible for coordinating mental health care follow up missed medication as part of an active care plan approach.
2. The Director 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:
 - Consulting prisoners to help determine what will help to keep them safe
 - Completing all necessary ACCT documentation fully and accurately
3. The Director should ensure that, in line with PSI 03/2013, all staff fully understand and follow the protocol for emergency medical codes.

Action Plan

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	<p>The Head of Healthcare should ensure that there are effective procedures to monitor prisoners' compliance with their medication and that nurses responsible for coordinating mental health care follow up missed medication as part of an active care plan approach</p>	Accepted	<p>A protocol has been introduced for prisoners who refuse high-risk medication. Medication defined as high-risk and highlighted in red on the nurse medication lists includes: diabetic medication, epilepsy medication, antipsychotic medication and heart medication.</p> <p>Nurses are required to speak to prisoners who do not collect medication defined as 'high risk', and the reason that the prisoner gives for refusing is then recorded on SystemOne. There is a specific process for prisoners who continue to refuse their medication which includes informing the safer custody department, and the relevant wing senior manager and operational manager. This information, together with a description of the possible effects on the prisoner, is documented in the wing ledger and PNOMIS is updated. A GP appointment is arranged and a medical review is held with the relevant staff within 72 hours.</p> <p>If a prisoner refuses medication which is not defined as 'high-risk', the doctor will decide whether it is appropriate to stop the medication, or whether a nurse should see the prisoner to discuss and review it. If the decision is taken for a nurse to see the prisoner, the nurse feeds back to the doctor within 24-hours.</p>	Completed	

Action Plan

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
2	<p>The Director 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:</p> <ul style="list-style-type: none"> ● Consulting prisoners to help determine what will help to keep them safe ● Completing all necessary ACCT documentation fully and accurately 	Accepted	<p>All residential managers and first line managers have received additional training in the ACCT process and the case management of ACCTs. The remaining managers will receive this training in January 2015, and all managers will be expected to attend refresher training annually. Through this training, managers have been reminded of the need to consult with prisoners when deciding what actions will be most effective in keeping them safe, and the importance of completing ACCT documentation fully and accurately.</p> <p>ACCT quality assurance checks will be completed fortnightly by the safer custody department. Any instances of procedures not being followed are brought to the attention of the safer custody manager who takes remedial action as necessary. In cases where there has been a serious failure in the process, an internal investigation is commissioned by the Director and disciplinary procedures take place. There is a monthly safer custody meeting at which ACCT quality assurance is a standing agenda item.</p>	<p>January 2015 and ongoing</p> <p>Head Of Safer Custody</p>	
3	<p>The Director should ensure that, in line with PSI 03/2013, all staff fully understand and follow the protocol for emergency medical codes.</p>	Accepted	<p>A Director's order has been issued explaining the emergency medical codes, and all staff have received cards advising them of the correct protocol.</p>	Completed	