

A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

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**Investigation into the death of a man in  
August 2014 at HMP Humber**

## ***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 hanged in his cell at HMP Humber in August 2014. He was 35 years old. I offer my condolences to his family and friends.

A clinical review of the man's clinical care at the prison was undertaken. Humber cooperated fully with the investigation.

The man was released from prison on licence on 10 May 2013. On 21 February 2014, he returned to prison after his licence was revoked following an assault and threats of violence to family members. On 17 July 2014, he made a superficial cut to his arm after a visit from his family, but said that he did not have any thoughts of suicide. In August 2014 an officer found him hanging in his cell.

While the man was appropriately identified as at risk of suicide or self-harm on 17 July, I am concerned that subsequent procedures were not completed properly and support was ended without action being taken to address the underlying reasons for his distress. Nor am I satisfied that the concerns of his family about his well-being were fully taken into account. Although it would not have affected the outcome for him, the prison did not call an ambulance as soon as an emergency code was called. I am also concerned that prison staff did not cut the ligature when they found him, but left him hanging until the police arrived. This was undignified and unnecessary.

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**

**June 2015**

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## SUMMARY

1. The man was released on licence from HMP Humber on 10 May 2013. He was recalled to prison at HMP Hull on 21 February 2014 and sent back to Humber on 28 February.
2. On 17 July, after a visit from his family, the man harmed himself by superficially cutting his left arm. This was the first time that he had self-harmed himself in prison. Staff managed him under suicide and self-harm prevention procedures, known as ACCT, but ended the procedures after 24 hours. ACCT observations were not completed or recorded as they should have been. His family raised concerns with the prison about him on several occasions, but these were not always dealt with effectively.
3. On 6 and 7 August, the man had several difficult telephone calls with his father, who told him that the man's relationship with his girlfriend was over. (She told us during the draft report consultation that she had not ended their relationship, and she was not aware that the man's father had said this to him.) At 5.57am, a night patrol officer saw him hanging in his cell from bedding attached to the window bars. He radioed a medical emergency code and went quickly into the cell to check for signs of life. There was a nine minute delay before prison staff called an ambulance. When officers examined him it was apparent that he had been dead for some time and resuscitation would not be possible. However, they did not cut the ligature and left him hanging in his cell until the police arrived some time later.
4. We are not satisfied that the man was appropriately supported after he self-harmed on 17 July. ACCT suicide and self-harm monitoring procedures were not completed properly and the support ended too soon, after less than one day, without any evidence to suggest that anything had been done to address the underlying reasons for his distress. We do not consider that staff appropriately dealt with concerns raised by his father. Although it would not have affected the outcome for him, the control room did not call an ambulance immediately the medical emergency was called, as should have happened. Prison staff should not have left him hanging until the police arrived and did not follow expected emergency procedures. We make four recommendations.

## THE INVESTIGATION PROCESS

5. The investigator issued notices to staff and prisoners at Humber, informing them of the investigation and inviting anyone with relevant information to contact him. No one responded.
6. The investigator visited Humber on 12 August and obtained copies of the man's prison and healthcare records. NHS England appointed clinical reviewers to review his clinical care. The investigator interviewed 14 members of staff and one prisoner at Humber. On 1 October, he informed the Governor about his preliminary findings.
7. The investigator informed HM Coroner for East Riding of Yorkshire of the investigation. We have sent the Coroner a copy of this report.
8. One of the Ombudsman's family liaison officers contacted the man's family to inform them of our investigation and to invite them to identify any relevant issues they wanted the investigation to take into account. They were concerned that:
  - He did not receive adequate physical or mental healthcare;
  - He was being bullied by other prisoners for his medication;
  - He did not receive appropriate counselling;
  - He was not being monitored as a risk of suicide at the time of his death, despite the recent death of his mother, a recent incident of self-harm, and a number of calls they had made to the prison to express concerns for his safety.

## **HMP HUMBER**

9. HMP Humber is made up of two former prisons, HMP The Wolds and HMP Everthorpe. The prison currently operates separate regimes on the two sites, which will eventually physically merge, and holds up to 1062 prisoners. The man lived on the Everthorpe site. There are seven residential units on the Everthorpe site.
10. Healthcare services are provided by Humber NHS Foundation Trust. Services are staffed during the day and there is an on call doctor at night.

## **HM Inspectorate of Prisons**

11. HMP Humber has not yet been inspected. HMP Everthorpe's last inspection was in March 2012, which was a follow up of a full inspection in 2009. Inspectors found that Everthorpe was generally a safe and decent establishment. They noted that consultation with prisoners about issues of self-harm had improved. As there was no definition of what constituted a serious incident of self-harm, inspectors were not fully assured that all such incidents were investigated. ACCT refresher training was not up to date. Inspectors noted some improvement in health services.

## **Independent Monitoring Board**

12. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In the last IMB annual report for HMP Everthorpe, for the year to October 2013, the IMB was satisfied that the prison was well managed and that prisoners were treated with dignity and respect. The IMB noted that a shortage of healthcare staff had impacted badly on standards of care during the year but this had been addressed. The departure of the safer prisons co-ordinator had also led to some problems with the management of safer custody, but a new coordinator was now in place.

## **ACCT - Assessment Care in Custody and Teamwork**

13. Assessment, Care in Custody and Teamwork, known as ACCT, is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Support for prisoners includes setting a number of significant interactions with them during the day, supplemented by checks on their well-being during the times they are locked in their cell.
14. Part of the ACCT process involves assessing immediate needs and drawing up a care-map to identify the prisoner's most urgent issues and

how they will be met. Regular multidisciplinary reviews should be held. The ACCT plan should not be closed until all the actions of the care-map have been completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

### **Previous deaths at Humber**

15. Since 2004, there have been two self-inflicted deaths at the Everthorpe site, one in 2006, the other in January 2014. In our report into the last death, we made recommendations about the operation of ACCT and emergency response procedures. We discuss these issues in this report.

## KEY EVENTS

16. The man was convicted of kidnapping on 30 March 2009, and sentenced to 7 years and 4 months in custody. He was sent first to HMP Hull and then transferred to HMP Everthorpe, on 14 September 2009. On 4 January 2012, he was released from prison on licence. On 15 September 2012, he was recalled to prison for breaching his licence conditions. He went back to Everthorpe on 28 September 2012 and was released on licence again on 10 May 2013.
17. On 21 February 2014, the man was recalled a further time, after he had assaulted his father and threatened to kill his girlfriend. When he arrived at HMP Hull, a nurse saw him for an initial health screen. She recorded that he had a below left knee amputation and a prosthetic limb, which he managed himself. He said that apart from his leg, he was physically well. She noted that he had an appointment with an orthopaedic surgeon on 26 February which needed to be rearranged. She noted that he had been prescribed pain relief and a laxative by his community doctor. He said he had no thoughts of suicide or self-harm.
18. On 28 February, the man was transferred to Humber. When he arrived, a nurse conducted another initial health screen and noted his medications and that he had a hospital orthopaedic appointment. He told the nurse that his mother had died suddenly from cancer in December 2013, and he was the main carer for his father who had been diagnosed with multiple sclerosis.
19. Between 29 February and 16 July, the man had 22 interventions with the healthcare team, including appointments with prison doctors, nurses, a mental health nurse, a physiotherapist, an optician and a dentist. He attended hospital orthopaedic appointments about his leg in April and June.
20. Between 13 March and 15 May, the man had seven bereavement counselling sessions with a volunteer counsellor from Cruse Bereavement Care (a charity that provides bereavement counselling at Humber, arranged by the chaplaincy team). On 13 May, his offender supervisor spoke to him about the counselling. He told her that he had benefitted greatly and praised the counsellor's support.
21. On 16 April, the man's father called the prison as he was concerned about his son's mental state. An officer called the wing and said that the man was in good spirits. Over the next month, the man's father phoned several more times with concerns about his son's mental state and leg problems. Prison staff made a record of each call, but it is not always clear what they did as a result.
22. The man had a single cell on the ground floor to help him get about. He worked as a wing cleaner, a job that he had done before in prison, and attended the gym. The man's personal officer said that the man

frequently phoned his father, who often visited him together with his girlfriend.

23. On the afternoon of 17 July, the man's girlfriend and father visited in the afternoon. Immediately afterwards, he cut his left arm superficially. At 4.45pm, an officer opened an ACCT document and recorded that the man's father had told him during the visit that he was seriously ill and had not long to live (although he has told us that he did not say this during this visit). The officer asked a nurse to see him.
24. A nurse examined the man and noted he had a minor cut to his left arm. She applied a dry dressing. He said that he did not feel suicidal and that he had cut himself impulsively, not as an attempt to kill himself. As an ACCT had been opened, she removed his medication from his cell and arranged for him to be given it daily and supervised when taking it.
25. A Supervising Officer (SO) completed an ACCT immediate action plan at 5.45pm. He noted that a nurse had treated the man's wound and that he knew how to access the Samaritans telephone and Listeners (Samaritan trained prisoners). The SO set the level of observations at five an hour and allowed him to phone his family from the wing office. The SO recorded in the ACCT document that he was remorseful about his actions.
26. Each observation was recorded in the ACCT document until 9.00pm. After this, a night patrol officer made one entry each hour throughout the night summarising the checks he had made in the previous hour. He said that a custodial manager, who was in charge of the prison that night, had instructed him to do this.
27. On the morning of 18 July, an officer checked the man at 7.45am, and recorded that she had spoken to him as he was awake. She noted that his cell was tidy and he was on the bed. The next recorded entry was at 8.30am, when he went to the healthcare unit for a pre-planned review.
28. The man told a mental health nurse that he had cut himself after his father told him that he had two years to live. She recorded that he had never self-harmed before and the incident was an inappropriate impulsive response. They discussed strategies to improve his motivation, including keeping a mood diary, which he said he was keen to try. She recommended that the ACCT be closed as soon as possible. She told the investigator that she thought that being on the ACCT would have added to his concerns. She noted that she would see him again in two to three weeks.
29. At 11.00am, an officer interviewed the man for an ACCT assessment. He said that he had harmed himself out of frustration and now felt very embarrassed. He said he was very close to his father and had been his main carer. He said he had spoken to his father the previous night, who had told him not to worry. She noted that he had never self-harmed or

attempted suicide before. She also spoke to the mental health nurse, who said that he had cut himself impulsively in response to the bad news about his father and she did not think he needed to be managed under ACCT procedures. He told the officer that he had no thoughts of suicide or self-harm and he said no. She recommended that the ACCT should be closed, and wrote that “on a scale of 1 to 10 (10 being of most harm) he is at minus 200”.

30. At 11.10am, a custodial manager chaired an ACCT first case review, which the officer and the man attended. He recorded that the mental health nurse contributed by phone. (Although it is mandatory for a member of the healthcare team to attend the first ACCT case review, he was clear about the nurse’s views.) The man said that he regretted his actions, which were completely out of character. The custodial manager recorded that the nurse had no ongoing concerns about him and was happy for the ACCT to be closed. He recorded that the man was at low risk of suicide and self-harm and that the ACCT should be closed. A post-closure interview was scheduled for 25 July.
31. Some time on 18 July (the time is not recorded) the man’s father rang the prison. He said he was concerned about his son and would like someone to contact him. It is not clear from the record of the call what action was taken as a result and there is no evidence that anyone called him back.
32. On 22 July, a nurse examined the man, who had pain in his stump. The nurse recorded that the stump was not inflamed or hot to the touch and advised him to come back to the healthcare unit if he had any further concerns. The nurse noted that the ACCT document had been closed and he could now have his medication in his possession.
33. On 25 July, a custodial manager held an ACCT post-closure review. The man said that his father had visited him again and they had talked things through. Although the issues were still there, he had come to terms with them. He said he had no other concerns and knew he could talk to officers and healthcare staff at anytime. He said he liked his work as a wing cleaner, attended the gym and enjoyed reading.
34. The man kept a diary that was found after he died. On 27 July, he wrote that he was upset that his girlfriend’s phone was switched off when she had told him to ring her. That evening his father called the prison to say he was concerned about his son’s mental state. An operational support grade spoke to an officer, who told him that the man was fine, and the operational support grade telephoned the man’s father to reassure him.
35. On 28 July, the man saw a prison doctor, as he had headaches which he thought might be due to his prescribed antidepressant. The doctor changed the medication. The next day, he told a nurse he had a heat-related headache. She gave him paracetamol and advised him to drink plenty of fluids.

36. On 1 August, the man wrote in his diary that his girlfriend had been “really funny” with him. On 3 and 4 August, he wrote about concerns he had with his relationships with his father and with his girlfriend.
37. On 6 August, the man made three telephone calls to his father at 3.42pm, 4.20pm and 5.28pm. The investigator listened to recordings of these calls. (All prisoners’ calls (except those which are legally privileged) are recorded for security purposes, although staff listen to only a random selection.) He accused his father of being in a relationship with his girlfriend (which they have both told us was not true) and he said that his father did not believe that another family member had sexually abused him when he was a child. He told his father that he was going to report the abuse to the police. His father said that he had lost his girlfriend and she did not want anything more to do with him, and that he needed to get his head straight. He rang his girlfriend at 6.12pm. The call lasted 40 seconds, as she said that it was not convenient to speak. She agreed that he could call her the next day.
38. On 7 August, the man phoned his father at 9.10am, 10.00am and 5.11pm. He told his father that he knew he was hiding things from him and he was going to speak to the police about the historical sexual abuse. He said that he had arranged to speak to his girlfriend at 3.00pm. His father again said that his son’s relationship with his girlfriend was over and she would not visit him. He also said that he would not take sides in the allegations about the historical sexual abuse. He said that he would book one more visit and that might be the last time they would see one another. The man tried to call his girlfriend several times that afternoon, but got no reply.
39. The last call the man made, at 5.11pm, was to his father. He said that he had not been able to speak to his girlfriend. His father said that she was not with him. He said that he was planning to see the mental health team the next day. His father said that he would come and see him and that he would never turn his back on him. He asked his father to ask his girlfriend to come as well. His father said that he would ask her but that he did not think that she would. The call ended amicably. In his diary for that day, he wrote that his girlfriend had “her phone off. She hates me this is the day I die”.
40. Another prisoner told the investigator that during evening association he and the man drank some ‘hooch’ (illicitly brewed alcohol) that he had obtained. He said the man had told him that his girlfriend was in a relationship with his father and that he was going to speak to the police about sexual abuse he had suffered as a child. The prisoner said that he went to his cell around 7.30pm, when prisoners were locked up for the night. He said when he left him he appeared to be fine.

41. Shortly before 8.00pm, the man's personal officer was going off duty. He told the investigator that he had spoken to him through the observation panel in his cell door and that he had seemed his usual self.
42. Day staff handed over to the night patrol officer and did not mention any concerns or issues about the man. He said that he did a roll check (a physical count of all prisoners on the wing) at 9.00pm. He had no concerns about him at the time.
43. At 5.57am the night patrol officer checked all the prisoners again. When he arrived at the man's cell, he saw, through the observation panel, that he was hanging from bedding tied to the window bars. He immediately radioed a code blue emergency. (This indicates someone is unconscious or not breathing and should prompt the control room to call an ambulance immediately.)
44. Staff on prison wings at night do not usually carry a full set of keys, but have a cell key in a sealed pouch for use in an emergency. The night patrol officer used his emergency key and went into the cell, followed by an officer and the custodial manager in charge of the prison that night, who had both responded quickly to the code blue. They could not find any signs of life. The custodial manager told the investigator that the man was cold and his body was stiff. It was evident that he had been dead for some time and it would have been futile to try cardiopulmonary resuscitation. She ordered the staff to leave the cell, and left him where they had found him to preserve the scene.
45. Ambulance Service records show that the 999 call was made at 6.06am. (The incident log shows the time as 6.04am.) Paramedics arrived at 6.16am and, at 6.26am, confirmed that the man had died. The police arrived shortly afterwards and their scene of crime officer cut the ligature from which he was hanging. The police told the investigator that, although he appeared to be in a sitting position, he was 10 to 15cm off the ground.

### **Contact with the man's family**

46. The prison family liaison officer and an officer visited the man's father at approximately 9.25am to inform him of his death and to offer condolences and support. The prison maintained contact with the family for ongoing support and offered financial help towards the funeral expenses, in line with national guidance.

### **Support for prisoners and staff**

47. The deputy governor told the investigator that a debrief was held to discuss what had happened and to offer the services of the prison's care team. However, there is no record of the debrief and staff involved in the emergency response told the investigator that they were not debriefed.

48. Staff, including members of the chaplaincy supported prisoners affected by the man's death. A senior manager stayed on the wing that morning to deal with any questions from prisoners and ensure they got support if they needed it. Staff reviewed prisoners assessed as at risk of suicide or self-harm, in case they had been adversely affected by his death.

## ISSUES

### Management of risk of suicide and self-harm

49. Staff appropriately opened an ACCT after the man cut himself on 17 July. A SO completed an immediate action plan within an hour and assessed him as at raised risk of suicide and self-harm. He set the level of observations at five an hour. However, from 9.00pm, the night patrol officer recorded a summary of the observations he had made each hour, rather than each individual check at the time he made them. He said that the night orderly officer had asked him to record the ACCT observations in this way. Most of the hourly summaries record that he observed him five times an hour as required. However, the record indicates that between 5.00am and 6.00am the night patrol officer checked him only three times; between 6.00am and 7.00am he recorded that he had made two checks in the previous hour; and between 7.00am and 8.30am he noted only one check.
50. Prison Service Instruction (PSI) 64/2011, which sets out the Prison Service's framework for delivering safer custody procedures, has a mandatory instruction that staff must follow the level of observations and conversations as stated in the 'required frequency of conversations and observations' box on the front cover of the ACCT and that the observations must be recorded immediately or as soon as practicable thereafter. We do not consider that the practice of recording several checks at once complies with this instruction, and we are concerned that checks were not all completed in line with the specified frequency.
51. At the first ACCT review, the Chair assessed that the man was a low risk of suicide or self-harm even though he had harmed himself the day before. The Chair closed the ACCT as the man's mood had improved and a mental health nurse who had seen him, and the ACCT assessor, thought it was safe to close the ACCT. However, there is no evidence that he was given any ongoing support for the issue which had caused his self-harm – the bad news about his father's long-term illness. He described his act of self-harm as a cry for help, but after the next day was not given any further help. He spoke to his father on 18 July, and his father was concerned enough about his state of mind to phone the prison. We consider that the ACCT was closed too early, less than 24 hours after he had self-harmed and before proper support was put in place. The decision appears to have been largely based on him saying that he felt all right at the time.
52. The man's family queried whether he had been bullied at the prison and whether this was a factor which had increased his risk of suicide. The investigator checked and there was no security intelligence that indicated that he was the victim of bullying at the prison. There was no other evidence linking with him bullying and nothing to suggest that bullying was a factor in his death or that the prison should have supported him under ACCT procedures as a result.

53. The man was briefly supported under ACCT procedures. However, the observations were not completed and recorded properly, and we consider that the ACCT was closed prematurely, before he had received proper support. We make the following recommendation:

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

- **Assessing the level of risk and recording the reasons for decisions;**
- **Conducting ACCT observations at the specified frequency;**
- **Recording ACCT observations immediately or as soon as possible after they are made;**
- **Continuing ACCT monitoring until the risk posed by the prisoner has reduced and all caremap actions have been completed.**

#### **Handling information from families**

54. The man's father telephoned Humber several times because he was concerned about his son's state of mind and physical health. The calls were recorded in log entries and most of the concerns were passed to wing officers or the healthcare team. However, staff only recorded the outcome of the call on three of the nine records. None of the calls were recorded on his prison record (NOMIS), although his personal officer noted, on 21 July, that the man's father called frequently, especially if he had not heard from him
55. Prison Service Instruction 64/2011, which contains guidance on safer custody, states that:

*All staff who receive information, including from concerned family members ... must communicate their concerns immediately to the Residential, Daily or Night Operational Manager, and/or consider opening an ACCT Plan and make a record in an appropriate source e.g. observation book, NOMIS, Security Information Report, ACCT Plan.*  
[The italics denote that this is a mandatory instruction]

The instruction goes on to say:

*Any member of staff who receives information, including that from family members or external agencies, or observes behaviour which may indicate a risk of suicide/self-harm must open an ACCT by completing the Concern and Keep Safe form.*

56. We are concerned that the calls provided evidence that the man may have been in low mood, but this was not collated in his prison record. On most occasions, there is no evidence of action being taken as a

result of the calls or that staff considered opening an ACCT. One of the calls was received on the day the ACCT was closed (18 July), when the man's father said that he was concerned about his son, but there is no evidence that this was considered as information which might indicate an increased risk of suicide or self-harm. We make the following recommendation:

**The Governor should ensure, in line with PSI 64/2011, that staff report any concerns from families about a prisoner's state of mind to an appropriate manager, consider whether to open an ACCT and record the information and action taken in the prisoner's record.**

### **Clinical Care**

57. The clinical reviewers found that the care the man received at Humber was comparable to that he could have expected to receive in the community. He was appropriately re-referred to an orthopaedic consultant by the prison doctor after he was recalled to custody. He attended outpatient appointments and there was a clear plan for his ongoing care.
58. The man sought support and advice from primary care mental health services while he was at HMP Humber, but did not reveal the depth of his personal unhappiness to healthcare staff. He received and engaged with bereavement counseling sessions which he said he found helpful.

### **Emergency Response**

59. The night patrol officer found the man hanging in his cell at 5.57am and radioed a code blue emergency. Prison Service Instruction (PSI) 03/2013 – Medical Emergency Response Codes requires prisons to call an ambulance immediately and automatically when an emergency code is called. However, according to Ambulance Service records, prison staff did not call an ambulance until 6.06am.
60. We raised the issue of emergency response in an investigation report into a death at Humber in January 2014. The report was issued in July 2014, and we made a recommendation to the Governor. In response, the Prison Service told us that a briefing had been issued which would form part of further training in September 2014. The man died in August before the planned further training had taken place but all that is required is a simple automatic response to a code being called. This did not affect the outcome for him, as it is apparent he had been dead for some time, but in other emergencies such a delay could be crucial. We are concerned that key staff in the prison's control room did not follow a mandatory national instruction which was issued in February 2013 or the local procedure. We make the following recommendation:

**The Governor should ensure that all staff working in the prison's control room follow the emergency procedures and call an ambulance as soon as an emergency code is broadcast.**

61. We are concerned that prison staff did not cut the ligature when they found the man hanging which was left until the police arrived. Prison Service Order (PSO) 1400 ("Incident Management") provided guidance for staff on what actions to take when they discover an apparent death. In Chapter 5, the PSO stated that when a prisoner was found hanging, staff should:

"Ask for immediate medical assistance and ambulance. Ensure your own safety first. Render first aid as appropriate. If the incident has occurred by hanging:

- a. first support the body to reduce constriction
- b. cut the inmate down
- c. remove the ligature and retain in the cell
- d. place the prisoner onto his back on a flat surface
- e. check for signs of life
- f. if the prisoner is not breathing attempt resuscitation
- g. if conscious/revived, place in the recovery position
- h. disturb the scene as little as possible"

PSO 1400 was replaced in March 2014 by Prison Service Instruction 09/2014. The new instruction does not contain guidance on actions when a prisoner is hanging but we consider that the same principles should apply.

62. We are satisfied that it was appropriate for officers not to try to resuscitate the man as there were no signs of life and rigor mortis was evident. European Resuscitation Council Guidelines for Resuscitation 2010 state that "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile ..." However, we consider that staff should have cut the ligature and placed him on his back before checking for signs of life. Leaving a prisoner hanging is not a safe or respectful procedure. We make the following recommendation:

**The Governor should ensure that prison staff who find a prisoner hanging, cut the ligature, lay the prisoner on a flat surface and check for signs of life as soon as possible.**

## RECOMMENDATIONS

1. The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:
  - Assessing the level of risk and recording the reasons for decisions;
  - Conducting ACCT observations at the specified frequency;
  - Recording ACCT observations immediately or as soon as possible after they are made;
  - Continuing ACCT monitoring until the risk posed by the prisoner has reduced and all caremap actions have been completed.
2. The Governor should ensure, in line with PSI 64/2011, that staff report any concerns from families about a prisoner's state of mind to an appropriate manager, consider whether to open an ACCT and record the information and action taken in the prisoner's record.
3. The Governor should ensure that all staff working in the prison's control room follow the emergency procedures and call an ambulance as soon as an emergency code is broadcast.
4. The Governor should ensure that prison staff who find a prisoner hanging, cut the ligature, lay the prisoner on a flat surface and check for signs of life as soon as possible.

## 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 Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:</p> <ul style="list-style-type: none"> <li>• Assessing the level of risk and recording the reasons for decisions;</li> <li>• Conducting ACCT observations at the specified frequency;</li> <li>• Recording ACCT observations immediately or as soon as possible after they are made;</li> <li>• Continuing ACCT monitoring until the risk posed by the prisoner has reduced and all caremap actions have been completed</li> </ul> | Accepted              | <p>All ACCT documents will be checked on a weekly basis by the Safer Custody, Custodial Manager. Any deficiencies will be reported to the wing manager for immediate action. A weekly report detailing these checks and the findings, along with a copy of each care map will be completed and presented at the weekly Residential group meeting. The Custodial Manager of the relevant wing will then meet with the Head of Safety to discuss the report with particular reference to trends and staff training needs. The report will highlight individual training needs amongst staff and allow specific support to be given. If staff continue to show deficiencies following additional support and training their performance will be escalated to the Deputy Governor for poor performance monitoring. Following a period of monitoring the weekly reports, this process will lead to wings receiving specific deficiency notices that require action within 24hours. However, initially to gain a full understanding of the issues to change and challenge staff performance a weekly report will be produced. It is anticipated the deficiency notices will be issued after a three month period of monitoring and additional support to wings. Staff will then be monitored and placed on support and management plans if they consistently fail to deliver care in line with national guidance.</p> | Target date for completion<br>31 Mar 15             |   |

|   |   |          |  |  |  |
|---|---|----------|--|--|--|
|   |   |          | <p>A training programme is in place for all custodial managers to refresh themselves on ACCT (Assessment, Care in Custody and Teamwork) procedures. This includes assessing the level of risk and accurately recording defensible decisions. This will be completed by April 15.</p> <p>The wider staffing group, including partner agencies, will receive ACCT foundation training as part of a monthly lockdown training session. All staff will be trained in ACCT foundation by end of Dec 15.</p>   | <p>Target date for completion: 30 April 2015</p> <p>Target date for completion 31 Dec 15</p> |  |
| 2 | The Governor should ensure, in line with PSI 64/2011, that staff report any concerns from families about a prisoner's state of mind to an appropriate manager, consider whether to open an ACCT and record the information and action taken in the prisoner's record. | Accepted | <p>Through local ACCT training, all staff have been reminded of the correct procedure for documenting all external calls and concerns on NOMIS and on opening ACCT documents when families raise concerns about a prisoner's state of mind. All concerns will be assessed with a view to opening an ACCT document or reviewing already open ACCTs, where appropriate.</p> <p>A Staff Information Notice detailing the procedure to deal with any concerns about a prisoner's state of mind will be issued by 28 February 2015. All staff will be reminded to record the concerns raised by outside parties and the subsequent action taken, on an ACCT document and NOMIS.</p> | Target date for completion 28 Feb 15   |  |
| 3 | The Governor should ensure that all staff working in the prison's control room follow the emergency procedures and call an ambulance as soon as an emergency code is broadcast.   | Accepted | <p>A Staff Information Notice was issued on Feb 13<sup>th</sup> 2015 detailing the correct medical code procedures to follow as soon as an emergency code is broadcast. Contingency plan exercises will also incorporate the procedures the control room should follow. This will ensure the ambulance protocol is fully understood. Safer Custody and Operations departments will audit all medical emergency calls to ensure compliance.</p>   | Target date for completion 31 Mar 15   |  |

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| 4 | The Governor should ensure that prison staff who find a prisoner hanging, cut the ligature, lay the prisoner on a flat surface and check for signs of life as soon as possible. | Accepted | A Staff Information Notice was issued on 13 February 15 detailing the correct procedure. The appropriate procedure has also been discussed with staff at debriefing sessions. | Completed |  |
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