Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Christopher Parker, a prisoner at HMP Holme House, on 12 November 2020

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

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

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Christopher Parker was found hanged in his cell on 12 November 2020, at HMP Holme House. He was 35 years old. I offer my condolences to Mr Parker's family and friends.

Mr Parker had a number of risk factors that indicated he was at high risk of attempted suicide and self-harm. When he arrived at HMP Durham, staff did not start ACCT monitoring.

After Mr Parker self-harmed on 22 October 2020, at HMP Holme House, staff started ACCT monitoring. We found deficiencies in the way ACCT procedures were managed. The investigation also found some weaknesses in the emergency response, although I cannot say if these deficiencies affected the outcome for Mr Parker.

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

Sue McAllister, CB
Prisons and Probation Ombudsman **June 2022**

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Summary

Events

1. In December 2017, Mr Christopher Parker was sentenced to four years and 10 months in prison for robbery. He was released on licence from HMP Holme House in April 2020. He was recalled to HMP Durham in June after taking an overdose and breaching his licence conditions. He returned to Holme House later that month. Mr Parker had a history of attempted suicide, self-harm, mental illness and substance misuse.

2. Reception staff at Durham did not identify that Mr Parker was at risk of suicide and self-harm. Despite a range of risk factors being present, he was not managed under the Prison Service suicide and self-harm prevention procedures (known as ACCT).

3. On 29 June, Mr Parker transferred to Holme House.

4. On 22 October, Mr Parker self-harmed and prison staff started ACCT monitoring procedures. The same day, Mr Parker told prison staff that he had taken an overdose. Nurses assessed him in the prison's inpatients unit.

5. On 28 October, a mental health assessment concluded that Mr Parker was not mentally unwell. His mood was low as he believed that he was at risk from other prisoners because of his offence.

6. On 10 November, Mr Parker had an ACCT case review and said that he had no intention of harming himself. Those present assessed his risk as low and agreed to stop ACCT monitoring.

7. On 12 November, Mr Parker told a custodial manager (CM) and a prison officer that he was concerned about another prisoner who knew about the nature of his offence. The CM agreed to move Mr Parker to another houseblock.

8. At 4.00pm, an officer carrying out a routine check found Mr Parker hanging from a ligature attached to his toilet door. Staff and paramedics tried to resuscitate him, but at 4.45pm, it was confirmed that Mr Parker had died.

Findings

HMP Durham

9. When he arrived at Durham, reception staff did not identify that Mr Parker was at risk of suicide and self-harm. They did not start ACCT monitoring procedures as they should have done.

HMP Holme House

10. There were a number of failings in the management of ACCT procedures at Holme House. Observations were not always carried out in accordance with Mr Parker's ACCT plan, and they were often completed at predictable intervals.

11. Case reviews were not always multi-disciplinary and the ACCT caremap did not include specific actions to reduce Mr Parker's risk. An ACCT case review did not take place when there was a change in Mr Parker's behaviour, which indicated an increased risk of suicide and self-harm.

12. The officer who found Mr Parker unresponsive in his cell on 12 November 2020, did not have a radio and was unable to call an emergency medical code. This caused a slight delay in calling an ambulance.

13. The clinical reviewer concluded that Mr Parker's mental and physical healthcare was equivalent to that which he could have expected to receive in the community.

Recommendations

For HMP Durham

- The Governor of HMP Durham should ensure that reception, first night staff and all others who assess risk:
- consider and record all the known risk factors of a newly arrived prisoner when determining their risk of suicide or self-harm.
- note and consider all information from all available records including their licence recall documents; and
- open an ACCT if a prisoner indicates that he is at risk of attempted suicide and self-harm, irrespective of his demeanour.

For HMP Holme House

- The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines. In particular, staff should:
    - hold multi-disciplinary ACCT reviews which take place within the set timescales.
    - set effective caremap objectives which are specific, time-bound and meaningful, aimed at reducing risk and updated at each case review.
    - carry out observations with the correct frequency.
    - vary times of ACCT checks, while remaining within set observation periods, to avoid prisoners being able to predict when they will be checked; and
    - ensure prisoners are reviewed after a change in their behaviour that indicates an increased risk of suicide or self-harm.
- The Governor should review the current provision of radios to ensure it is sufficient to meet the needs of the prison.
- The Governor should share this report with CM A and Officer A and arrange for a senior manager to discuss the Ombudsman's findings with them.

The Investigation Process

14. The investigator issued notices to staff and prisoners at HMP Holme House informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

15. The investigator obtained copies of relevant extracts from Mr Parker's prison and medical records.

16. NHS England commissioned a clinical reviewer to review Mr Parker's clinical care at the prison. The investigator and clinical reviewer interviewed 14 members of Holme House staff on 10 December 2020 and 17 June 2021. The interviews were conducted by video because of the restrictions in place during the COVID-19 pandemic.

17. We informed HM Coroner for Teeside of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

18. We wrote to Mr Parker's nominated next of kin, his mother, to explain the investigation and to ask if she had any matters, she wanted the investigation to consider. Mr Parker's family wanted to know:

    - how did Mr Parker receive the gash on his face?
    - was Mr Parker taking any illicit substances when he died?
    - was Mr Parker being monitored under ACCT procedures?
    - was there any evidence that Mr Parker had self-harmed or attempted to take his own life in the prison before he died?
    - how often did prison staff check on Mr Parker?

19. We have answered the family's questions in this report.

20. Mr Parker's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

21. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Holme House

22. HMP Holme House is a category C training prison holding over 1200 men. G4S provides health services at the prison. There is a 24-hour healthcare unit with 16 beds.

HM Inspectorate of Prisons

23. The most recent inspection of HMP Holme House was in February and March 2020. Inspectors reported that the safer custody team had undertaken some recent work to improve the quality of the ACCT case management process through stringent quality assurance, but it was too soon to judge its effectiveness. Inspectors found that in the sample of ACCTs they reviewed, case managers were not always consistent, and reviews were not always multidisciplinary. Some caremaps lacked detail and observational entries were often limited. The prisoners they spoke to who were being monitored under ACCT had mixed views about the quality of staff care and support.

Independent Monitoring Board

24. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year ending 31 December 2020, the IMB reported that staff referred 638 prisoners for ACCT monitoring during 2020. Inspectors said that the safer custody team encouraged active management and reviewing of the ACCT plan so that the case was not open for longer than necessary while the prisoner was kept safe

Previous deaths at HMP Holme House

25. Mr Parker was the 16th prisoner to die at Holme House since October 2018. Of the previous deaths, 12 were from natural causes, two were self-inflicted and one was drug related. There have been seven deaths since Mr Parker's death, three from natural causes, three were self-inflicted and one is awaiting classification.

26. In a previous investigation into the death of a prisoner at HMP Holme House in July 2020, we were concerned about the management of ACCT and recommended that observations are carried out at the correct frequency and at irregular intervals. The Prison Service accepted our recommendation and issued an action plan, which said that Holme House would issue a Governor's Order which highlighted the need for observations to be carried out at the frequency recorded in the ACCT document and that they must not be undertaken at predictable times. Holme House also introduced a weekly ACCT Quality Assurance and Coaching meeting to identify recurring issues in the ACCT process. It is disappointing that we are having to repeat this recommendation again.

Assessment, care in custody and teamwork (ACCT)

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

28. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

29. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction 64/2011, Management of prisoners at risk of harm, to self and from others (Safer Custody).

Incentives and Earned Privileges (IEP) Scheme

30. Each prison has an Incentives and Earned Privileges scheme which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and to wear their own clothes. There are three levels: basic, standard and enhanced.

Key Events

31. On 4 October 2017, Mr Christopher Parker was remanded to HMP Durham. On 18 December, he was sentenced to four years and 10 months in prison for robbery. On 30 June 2018, he transferred to HMP Holme House. On 1 April 2020, Mr Parker was released on licence to an Approved Premises. He was recalled to Durham on 13 June, after taking an overdose (believed to be heroin) and breaching the conditions of his licence. Mr Parker transferred to Holme House on 29 June.

HMP Durham

32. Mr Parker arrived at HMP Durham on 13 June. A prison officer completed his first night induction. Mr Parker's recall notification said that he was at the risk of death, given his recent overdose on what was believed to be heroin. It is not known whether this was an intentional or accidental overdose. The officer noted that Mr Parker did not have any thoughts of suicide or self-harm.

33. A nurse completed Mr Parker's initial health screen. She noted that he had a history of substance misuse and alcohol abuse, and was not taking any prescribed medication. Mr Parker said that he did not have any thoughts of suicide or self-harm. The nurse made a referral to the Drug and Alcohol Recovery Team (DART).

HMP Holme House

34. On 29 June, Mr Parker transferred to Holme House.

35. Prison staff completed a cell sharing risk assessment (CSRA), which recorded that Mr Parker was a standard risk for sharing a cell. In line with COVID-19 restrictions, Mr Parker was placed in isolation for 14 days. On 13 July, he was allocated a single cell on Houseblock 1. Mr Parker was not allocated a keyworker due to the COVID-19 restrictions. Prison staff completed regular welfare checks.

36. A nurse completed Mr Parker's initial health screen. She noted that he had cerebral arteriovenous malformation (abnormal blood vessels connecting arteries and veins in the brain) and was not receiving any medication or treatment for this condition. A prison GP saw Mr Parker in a virtual clinic and noted that he was under the care of the Royal Hallamshire Hospital. He referred Mr Parker to the complex care register, and nurses contacted the hospital about his consultant appointment on several occasions. Mr Parker did not see a consultant before he died.

37. On 12 August, prison staff found Mr Parker in possession of hooch (illicit alcohol). He was placed on the basic regime under the Incentives and Earned Privileges (IEP) scheme for a period of seven days.

38. On 7 September, Mr Parker referred himself to the prison's mental health team. On 12 September, a mental health nurse completed an initial assessment. Mr Parker said that he was feeling very anxious and was not sleeping. He told her that he had a history of self-harm in the community. She referred him for a secondary mental health assessment.

39. A mental health nurse saw Mr Parker on 23 September. Mr Parker said that he felt stressed because he suspected his victim's grandson was a prisoner at Holme

House. He also said that he had a history of self-harm and alcohol abuse in the community. She noted that Mr Parker did not have any mental health symptoms but was fearful for his safety. She told the investigator that she spoke to the Safer Custody team about Mr Parker's concerns and was told that the other person was not a prisoner at Holme House. She did not inform Mr Parker of this.

40. The next day, a prison GP prescribed Mr Parker sertraline (an antidepressant used to treat anxiety). Mr Parker was allowed to keep the medication in his cell. The same day, an officer completed a welfare check. Mr Parker said that he felt settled on Houseblock 1 and spent his time watching television, going on the exercise yard and using the kiosk.

41. On 3 October, a prison officer completed a welfare check. Mr Parker did not raise any issues or concerns and said that he was coping well with the restricted regime.

42. On 18 October, Officer A completed a welfare check. He noted that Mr Parker was in a good mood and he did not report any issues. Mr Parker was enjoying his new job as a wing painter because it occupied his time and gave him a routine outside of his cell.

Events of 22 October

43. At approximately 6.40pm on 22 October, Mr Parker self-harmed by cutting himself. A nurse saw Mr Parker and noted that he had made multiple superficial wounds to his skin, two small marks to each cheek and long multiple lacerations to both sides of his chest. None of Mr Parker's wounds needed stitches.

44. At 6.50pm, an officer began ACCT procedures because Mr Parker said that he had made cuts to his chest and face because he wanted pain relief medication and his mental health was 'through the roof'. A Senior Officer (SO) completed Mr Parker's immediate action plan and placed him on one observation an hour. A SO was appointed as the ACCT manager.

45. Mr Parker rang his cell bell at 8.30pm and asked about his painkillers. An officer noted that Mr Parker appeared disorientated. Prison staff found illicit alcohol in his cell.

46. At approximately 10.43pm, Mr Parker told prison staff that he had taken an overdose of sertraline and paracetamol. A nurse saw him and noted that he was alert and fully mobile and appeared intoxicated from illicit alcohol. Mr Parker refused to attend hospital, so he was admitted to the prison's inpatients unit. Nurses assessed Mr Parker using the National Early Warning Scale (NEWS2 - an assessment to determine a patient's level of illness) and noted that he scored 0. This is the lowest level on the scale and indicated a low level of clinical risk. Nurses referred him to the prison's mental health team.

ACCT: 23 October to 10 November

47. At 11.20 am on 23 October, a mental health nurse saw Mr Parker for an initial mental health assessment. She noted that Mr Parker's mood was low, and that he believed he was at risk from other prisoners because of his offence.

48. At 2.40pm, an officer carried out an ACCT assessment in the prison's inpatients unit. Mr Parker said that he had obtained illicit alcohol and had taken all his medication because he felt stressed and anxious. He said that he had no current thoughts of suicide or self-harm. He noted that Mr Parker needed to see the mental health team and have his medication reviewed.

49. At 3.30pm, a Custodial Manager (CM) completed the first ACCT case review. Mr Parker said that he had self-harmed while under the influence of illicit alcohol. There was no healthcare or mental health input. The CM noted that Mr Parker did not feel safe on a normal location houseblock due to the nature of his offence. The CM assessed Mr Parker as a low risk of suicide and self-harm. He added three actions to Mr Parker's caremap about his alcohol and substance misuse, the suitability of his pain relief medication and an application for his transfer to another prison.

50. A nurse saw Mr Parker again at 5.28pm, for a comprehensive mental health assessment. She concluded that Mr Parker was not mentally unwell, and he did not meet the criteria to be on the secondary mental health team's caseload. Mr Parker's stress was related to his view that other prisoners were going to assault him. She referred Mr Parker to the primary mental health team to receive support with coping strategies for stress. She told the investigator that the waiting time for an appointment was approximately two to four weeks.

51. At 6.15pm, healthcare staff and prison staff completed Mr Parker's formal discharge from the prison's inpatients unit before he returned to Houseblock 1. Mr Parker said that he was happy to move and had no feelings of suicide or self-harm.

52. On the 26 October, Mr Parker was referred for low intensity cognitive behaviour therapy to focus on managing stress. The same day, a nurse saw Mr Parker to assess if he was suffering from alcohol withdrawal or struggling with alcohol issues. Mr Parker showed no sign of withdrawal and did not need any treatment.

53. On 27 October, a SO carried out an ACCT case review. Mr Parker said that he felt safe on the houseblock and that drinking illicit alcohol had led to his self-harm and increased feelings of paranoia. Mr Parker said that he had no thoughts of suicide or self-harm. The SO assessed Mr Parker's risk as low and reduced his observations to one in the morning and afternoon, three observations during the night and one conversation a day.

54. On 30 October, a prison officer completed a welfare check. Mr Parker was polite and respectful and did not report any issues or concerns.

55. A SO completed an ACCT review on 3 November. There was no healthcare input. Mr Parker said that he regretted self-harming and drinking illicit alcohol. He did not have any feelings of suicide or self-harm. An officer reviewed Mr Parker's caremap. He considered that Mr Parker's risk remained low and reduced his observations to one during the day and one conversation.

56. On 9 November, a prison GP reviewed Mr Parker's medication because he wanted to stop taking sertraline. She noted that a GP should speak to Mr Parker before his medication was stopped and that another GP had arranged to speak to Mr Parker on the telephone on 11 November.

57. A SO completed an ACCT review on 10 November. An officer attended and there was no healthcare input. Another officer noted that Mr Parker was happy and engaged well. Mr Parker said that he had no thoughts of suicide and self-harm. Mr Parker's risk level remained unchanged and the actions on his caremap were complete. Both officers agreed to stop ACCT monitoring. The SO noted that the post-closure phase would end on 17 November. An alert to this effect was added to Mr Parker's NOMIS record (electronic prison record).

Events of 12 November

58. At approximately 11.00am, Mr Parker spoke to Officer A and said that he was concerned about another prisoner on the wing who he knew from HMP Durham and who was aware about the nature of his offence. Mr Parker told him that he had asked another officer if he could share his cell with the other prisoner (from Durham). The officer said that Mr Parker intended to assault the other prisoner so that he would be moved to the segregation unit. Mr Parker recognised that this was inappropriate but was concerned for his safety.

59. At approximately 11.30am, Mr Parker went to the wing office and spoke to CM A. Mr Parker shared his concerns about the other prisoner and asked for a move to Houseblock 4. The CM told the investigator that she checked Mr Parker's NOMIS and noted that he was able to associate with other prisoners without any restrictions. Mr Parker was assessed as suitable to share a cell.

60. CM A spoke to Officer A and asked him to arrange for Mr Parker to be moved to Houseblock 4 and a note was left in the wing office. There was no entry in Mr Parker's NOMIS record. The officer could not remember being asked to arrange for Mr Parker to move to Houseblock 4. He told the investigator that Mr Parker was upset and distressed before he went to his cell. He was not aware that Mr Parker was in the post-closure phase of ACCT monitoring.

61. At approximately 4.00pm, Officer A started a routine roll count at the end of afternoon association and went to Mr Parker's cell. He looked through the observation panel and saw Mr Parker hanging from the toilet door. Because he did not have a radio, he called for assistance from a colleague and pressed the emergency alarm. Another officer entered Mr Parker's cell and used his fish knife to remove the ligature. He started cardiopulmonary resuscitation (CPR), assisted by an officer. At 4.08pm, an officer radioed an emergency code blue (indicating a prisoner is unconscious or having breathing difficulties). The control room immediately called an ambulance.

62. Three nurses arrived at Mr Parker's cell and took over CPR. One nurse inserted an airway into Mr Parker's nasal passage to help him breathe and attached a defibrillator, which did not detect a shockable rhythm. Paramedics arrived at 4.16pm and took control of Mr Parker's care. Mr Parker remained unresponsive and at 4.45pm, the paramedics confirmed that Mr Parker had died.

Contact with Mr Parker's family.

63. The prison appointed two family liaison officers (FLO) and identified Mr Parker's mother as his next of kin. At 11.50am, they visited Mr Parker's mother at her home,

but she was not there. Both FLOs went to Mr Parker's mother's work address and broke the news of his death.

64. The prison contributed towards the cost of Mr Parker's funeral, in line with Prison Service guidance.

Support for prisoners and staff.

65. A prison manager held a debrief on the day of Mr Parker's death to offer support to the staff involved in the emergency response and to ensure they had the opportunity to discuss any issues. The staff care team also offered support.

66. The prison posted notices informing other prisoners of Mr Parker's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Parker's death.

Post-mortem report

67. The pathologist concluded that Mr Parker died from hanging.

68. The toxicology report detected an alcohol concentration of 80mg/100ml in Mr Parker's blood. The pathologist said that this is the level at which driving a motor vehicle is permitted in England and Wales. This level may be associated with decreased reaction times and impaired judgment, although it was very much dependent on an individual's tolerance to alcohol.

Inquest

69. An inquest held on 15 May 2024, concluded a narrative verdict and said '… the deceased deliberately chose to suspend himself from a bedsheet but it is unclear whether he determined the outcome to be fatal …'

Findings

Management of Mr Parker's risk of suicide and self-harm

70. Prison Service Instruction (PSI) 64/2011 on safer custody, requires all staff who have contact with prisoners to be aware of the triggers and risk factors that might increase the risk of suicide and self-harm, and take appropriate action. (The risk factors were also listed in our thematic report published in 2014.) Mr Parker had several of these risks including previous self-harm, poor mental health, and licence recall.

71. Mr Parker's licence was revoked after he took an overdose in an Approved Premises. The recall paperwork said that it was not known if the overdose was intentional or accidental. There is no evidence that prison staff assessed Mr Parker's risk of suicide or self-harm when he arrived at Durham on 13 June. We consider that given Mr Parker's recent self-harm, Durham should have started ACCT monitoring. We recommend that:

The Governor of HMP Durham should ensure that reception, first night staff and all others who assess risk:

- **consider and record all the known risk factors of a newly arrived prisoner when determining their risk of suicide or self-harm;**
- **note and consider all information from all available records including person escort records (PERs); and**
- **open an ACCT if a prisoner indicates that he is at risk of attempted suicide and self-harm, irrespective of his demeanour.**

72. When Mr Parker self-harmed at Holme House on 22 October, staff appropriately decided that he should be managed under the ACCT suicide and self-harm prevention procedures.

73. We consider that the ACCT procedures did not effectively support Mr Parker because the overall management of the ACCT was poor and not fully in line with PSI 64/2011. ACCT case reviews were not always multi-disciplinary and only two ACCT reviews were conducted by Mr Parker's case manager. Prison staff did not always complete observations in accordance with his ACCT document and observations were not always irregular.

74. Caremaps should reflect the prisoner's needs, level of risk and the triggers of their distress. Instructions say they should aim to address issues identified in the ACCT assessment interview and later reviews, and consider a range of factors including health interventions, peer support, family contact and access to diversionary activities. Each action on the caremap should be tailored to the individual needs of the prisoner, be aimed at reducing risk and be time bound. Mr Parker's caremap did not refer to his mental health, despite this being one of the triggers for starting ACCT monitoring.

75. Mr Parker was in the post-closure phase of ACCT monitoring when he hanged himself on 12 November. We consider that the decision to stop ACCT monitoring

was appropriate. There were reasonable grounds to assess that Mr Parker's risk had reduced and the actions on his caremap were complete.

76. On 12 November, Mr Parker approached Officer A and CM A because he was worried about another prisoner who had arrived on Houseblock 1. The CM agreed to move Mr Parker to another houseblock and asked the officer to arrange this. Mr Parker's anxiety was caused by concern for his own safety, and this was listed as a trigger on his ACCT plan. His behaviour was a cause for concern and suggested an increased risk of suicide and self-harm. We consider that the CM should have arranged an urgent case review to assess Mr Parker's risk and whether the ACCT needed to be re-opened. We consider that Holme House need to take steps to improve the ACCT process. We recommend that:

The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines. In particular, staff should:

- **hold multi-disciplinary ACCT reviews which take place within the set timescales;**
- **set effective caremap objectives which are specific, time-bound and meaningful, aimed at reducing risk and updated at each case review;**
- **carry out observations with the correct frequency;**
- **vary times of ACCT checks, while remaining within set observation periods, to avoid prisoners being able to predict when they will be checked; and**
- **ensure prisoners are reviewed after a change in their behaviour that indicates an increased risk of suicide or self-harm.**

Mental and clinical healthcare

77. The clinical reviewer concluded that Mr Parker's mental and physical healthcare was at least equivalent to that which he could have expected to receive in the community.

78. Mental health nurses saw Mr Parker after he self-harmed and completed two comprehensive assessments. Although Mr Parker said he was suffering from anxiety, the nurses considered that this was due to his concerns about other prisoners being aware of the nature of his offence. Mr Parker was referred to the primary mental health team for further support. The clinical reviewer said that the waiting time to access this service was comparable to waiting times in the community.

79. Mr Parker had cerebral arteriovenous malformation, which had caused him to suffer from seizures. He was not receiving any treatment for this when he came into prison. The clinical reviewer considered that Mr Parker's clinical care was appropriate, although there was a significant delay from the hospital in providing Mr Parker with any treatment advice or to give him a consultant appointment. We make no recommendation.

Emergency response

80. Although staff responded quickly when Mr Parker was found unresponsive, Officer A, who was first on scene, was unable to call an emergency medical code because he did not have a radio. He pressed the emergency alarm to alert staff that there was an emergency. The failure to call an emergency code would have caused a slight delay in calling an ambulance. We cannot say whether these delays would have made a difference to the outcome in Mr Parker's case but could make a critical difference in other medical emergencies.

81. We are concerned that a lack of available radios could cause unnecessary delays in other circumstances and could put officers at risk if they are unable to call for assistance. We recommend that:

The Governor should review the current provision of radios to ensure it is sufficient to meet the needs of the prison.

Learning lessons

82. We consider it essential that staff learn the lessons from our reports. We therefore recommend that:

The Governor should share this report with CM A and Officer A and arrange for a senior manager to discuss the Ombudsman's findings with them.

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