

**Investigation into the circumstances surrounding the
death of a man at HMP Rye Hill in April 2005**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

May 2007

This is the report of an investigation into the circumstances surrounding the death on 13 April 2005 of a man in his cell at HMP Rye Hill.

The man was found, fatally injured, at 3.55pm when a Prison Custody Officer on duty was alerted to the sound of a disturbance on the landing. He had suffered two stab wounds. Police subsequently recovered a knife, now known to be the murder weapon.

Prison medical staff was quickly present. An air ambulance crew attended and the doctor in charge performed open heart surgery where the man lay. Despite the efforts of the medical teams, the doctor pronounced the man dead at 4.50pm. He was 44 years old and had been at Rye Hill for about six months before he was killed.

A Doctor, who performed the first post mortem examination on 14 April 2005 at Leicester Royal Infirmary, found the cause of death was identified as: stab wounds to the chest. A second Doctor performed a second autopsy at the same hospital, and agreed the first Doctors findings. A supervised a toxicological re analysis was performed.

I offer my sincere sympathy and condolences to the man's family for their tragic loss in such shocking circumstances.

On 6 April 2006, two men were found guilty of the man's murder. Both were sentenced to life imprisonment with recommendations that one serve a minimum of 15 years and the other a minimum of 14 years. A third man was sentenced to 2½ years imprisonment for assisting an offender.

Another Investigator started this investigation on my behalf. However, when he became involved in monitoring performance improvement at Rye Hill for the Office of Contracted Prisons, I judged it right to pass responsibility to my Deputy Ombudsman, who concluded the investigation and compiled the report. She also conducted a clinical review of the man's treatment during the time he was at Rye Hill

Detective Superintendent who led the criminal investigation willingly shared information and kept in touch with the Ombudsman's office in the period leading up to and after the criminal trial. I am grateful to the Detective Superintendent and his team for their comprehensive face-to-face briefings, and for copying and supplying us with numerous documents. My thanks also go to the Director and staff at Rye Hill.

Because of the criminal proceedings, this report is much shorter than those I normally issue following a death in custody. Its preparation has also been much delayed for the same reason. In all the circumstances, which include a highly critical report on Rye Hill from HM Chief Inspector of Prisons and the imposition on the contractor, GSL, of a Rectification Notice, I have not felt it sensible to include recommendations of my own as they would simply duplicate those that have been made elsewhere.

I regret the delays and limitations that the criminal trial and subsequent mislaying of original documents have caused. This I know has added to the distress that the man's family has experienced. I hope that an inquest will provide the family with an opportunity to gain answers to other questions this report has been unable to answer.

This report has been anonymised for publication on the PPO website.

Stephen Shaw CBE
Prisons and Probation Ombudsman

May 2007

CONTENTS

Summary	5
The investigation process	6
The Man	8
HMP Rye Hill	9
Issues arising from this investigation	11
Conclusions	18

Annexes

SUMMARY

On 13 April 2005, at about 3.55pm, the man, a prisoner at HMP Rye Hill, was in his cell when he sustained two stab wounds to his chest. Medical staff, including an air ambulance crew, attended the scene and performed emergency surgery. They were unable to save his life and his death was certified at 4.50pm.

The prison wing was evacuated. There was insufficient accommodation for all the prisoners who were displaced and many were transferred to other prisons so that the painstaking forensic work could be undertaken.

The trial of three men, all serving prisoners, was held at Northampton Crown Court. On 6 April 2006, two men were found guilty of the man's murder and sentenced to life imprisonment with recommendations of minimum terms of imprisonment of 15 years and 14 years respectively. The third man was found guilty of assisting an offender and sentenced to two and a half years imprisonment.

The man had served a number of prison sentences. At Rye Hill he was serving seven years imprisonment, having first been remanded into custody in December 2000. He had been in several prisons during this sentence. He was at Rye Hill for about six months. He was due to be discharged from custody on 18 April 2005, just five days after he died.

The man's life in prison had its ups and downs. On the one hand, he had been the subject of no fewer than 20 disciplinary reports for various offences, including one of failing to return to prison following a period of home leave. On the other hand, he had completed many courses in prison and had gained awards for successfully completing a number of courses including one on community sports leadership. During the middle period of his sentence, he had thrown himself wholeheartedly into participation in programmes and activities.

Prison life appeared to go somewhat downhill for the man following his failure to return from home leave in April 2004. Brushes with staff became more frequent and he apparently became more unsettled as the time for his release drew near. There is anecdotal evidence, in witness statements to the police and from information gathered from his mother that the man also had disagreements with fellow prisoners.

THE INVESTIGATION PROCESS

1. A very experienced former Prison Governor contracted to my team as an investigator opened the investigation. He made an initial visit to HM Prison Rye Hill and was briefed by the Director and safer custody manager. He also chaired a meeting attended by senior staff, police, those staff involved directly in the man's death (either having been on duty on the landing or assisting in emergency action), representatives of the trade union, the healthcare manager and police liaison officer. During several follow up visits, the investigator met members of the prison's Independent Monitoring Board, including the chair. As a result of the criminal investigation, my investigation was limited to reading witness statements as the investigator was unable to interview staff or prisoners.
2. Nevertheless, Northamptonshire police co-operated readily and shared all their witness statements, enabling the investigator to build up a comprehensive picture of events. He was also able to see and comment upon general security and safety arrangements at Rye Hill and his views are fully documented in this report. Permission is being sought from Northamptonshire Police to release the relevant material from their investigation.
3. The investigator, together with one of the Family Liaison Officers in my office, visited the man's family at their home. The family were understandably saddened and angry at his death and at the manner in which it occurred. I trust I have reflected their views and that this report goes some way to addressing their concerns. Regrettably, in the early stages of the investigation there appears to have been a failure of communication between my office, the family and their legal representatives. I apologise to the man's mother, her family and to her solicitors for any anxiety and distress this caused.
4. In January 2006, the investigation was passed from the Investigator to my Deputy Ombudsman following the investigator's appointment by the Office of Contracted Prisons to monitor the Rectification Notice placed on HMP Rye Hill. My Deputy Ombudsman has reviewed all the available evidence and spoken to the team from HM Inspectorate of Prisons about their findings when they inspected Rye Hill in April 2005. The inspection team were at the establishment when the man's murder occurred.
5. Unfortunately, despite considerable efforts by my investigators, at this stage it has not been possible to locate all the original documents from the man's time at Rye Hill. My investigators are working with the police to establish what documents they have in their possession following the criminal trial of the prisoners found guilty of the man's murder. I am aware his family has made a direct request to Northamptonshire Police to access those documents.
6. Consideration was given to obtaining transcripts of the court proceedings. However, the cost of obtaining these was felt to outweigh the likely additional information they would bring to the investigation.

7. My Deputy Ombudsman also conducted a clinical review in respect of the man's medical care during his sentence, and particularly during the months he was at Rye Hill. She met with the man's mother, his brother, and their legal representative, to explain the delays in issuing the report and the reasons for reallocating the case.
8. On completion of this report, a copy will be sent to Her Majesty's Coroner to assist with her enquiries. The man was murdered while in the care of the state, and an inquest before a jury will enable the family to ask questions of HMP Rye Hill not covered during the criminal trial.

HMP RYE HILL

9. HMP Rye Hill is situated near Rugby in Warwickshire. Built privately as a Design, Construct, Manage and Finance (DCMF) contract by Global Solutions Limited (GSL), the prison opened in early 2001. At the time of his murder, its work was regulated by the Office of Contracted Prisons which was part of the National Offender Management Service of the Home Office. There are two full time performance monitors on site to observe and report on the extent to which GSL comply with the terms of their contract.
10. At the time of our investigation, Rye Hill held 600 male adult sentenced prisoners. The majority of prisoners are young and serving long sentences, including life, for offences mainly of violence.
11. During its early years, Rye Hill gained a reputation as a 'good' prison being safe, secure and well organised. In her report of October 2003, following a full inspection, HM Chief Inspector of Prisons, noted that the prison was an example to all in the way it treated prisoners with respect. She also noted that the healthcare centre was particularly good in its counselling programmes. The Chief Inspector added, however, that a relaxed atmosphere can bring dangers when staff are young and inexperienced and at Rye Hill the boundaries were sometimes blurred. She recommended that managers give visible and intensive support to the first line Prison Custody Officers (PCOs) still finding their way in their first custodial roles.
12. However, by 2005 there were serious concerns about safety and security at Rye Hill. During an unannounced inspection of Rye Hill between 11-15 April 2005, the Chief Inspector found an environment that was not safe:

"Our own assessment was based upon evidence we collected during the week. Inspectors found inexperienced staff, in twos and sometimes alone, on a wing of 70 prisoners, who were unlocked for most of the time. Staff were inadequately supported by managers and were sometimes surviving by ignoring misbehaviour or evidence of illicit possessions. Prisoners themselves told us that they wanted a more visible, and a more robust, staff presence. We were shown mobile phones, and prisoners reported the presence of drugs, alcohol and knives. Prisoners also said that they themselves sorted out fights and bullying; and we saw evidence of staff being bullied by prisoners and withdrawing from, rather than confronting, intimidatory and aggressive behaviour."

"Rye Hill has considerable potential. It is a new, well-maintained prison, where prisoners are able to spend considerable time out of their cells. Prisoners, serving lengthy sentences, had an investment in ensuring order and safety on the wings, particularly as they did not want to have to return to a less open and more restrictive establishment. It was clear that staff were striving to provide a good environment for prisoners, from a basis of mutual respect. But at the time of the inspection it was apparent that this was not enough. Staff lacked the experience or support to ensure that the proper

boundaries were in place, take decisive action to challenge misbehaviour, or actively to support prisoners, including those who were vulnerable.”

13. At the end of 2005, the then Office of Contracted Prisons imposed a Rectification Notice on Rye Hill. The effect was to put the prison on notice that, unless it produced a satisfactory programme for improvement and subsequently implemented it, more stringent action would follow. GSL's performance improvement plan was accepted, and the Notice was lifted in January 2006. The prison's performance continues to be closely monitored and reviewed on a regular basis.
14. When the investigator and the Family Liaison Officer visited the man's mother and brother (the family's solicitor was also present), they were understandably angry at his death and the circumstances in which it had occurred. They questioned that staff so young should be in charge of prisoners, and said they had heard that Rye Hill was not a good prison

ISSUES ARISING FROM THIS INVESTIGATION

History of disagreements with others

15. The available security information reports (SIRs) completed by prison staff indicate that the man had been involved in a few disagreements with other prisoners and staff. One of these resulted in him being moved from Edwards wing to another residential unit. However, I have not yet been able to obtain all of his Rye Hill records to date, as these are apparently being held by Northamptonshire Police. As a consequence, I am unable to verify what entries if any have been made in his history sheet (a log of events also prepared by prison staff) concerning any incidents.
16. One of the men subsequently convicted of the man's murder, a prisoner also, told police in interview that he had a long-running disagreement with the man. He said it started when the man, who was serving breakfast at the time, threw the prisoners' jug of milk out of the servery door. The first prisoner was apparently intervening in an incident between the man and another prisoner. The first prisoner said that from then on, the man continued with an 'attitude' against him. The first prisoner said he also intervened when the man went to another prisoner's cell in a dispute about goods from the prison shop. This later incident appears to have taken place on Tuesday 12 April, as the first prisoner told the police that he had resolved to 'deal with it' the day after – the day the man died. He also said that 'some other people' would come with him to confront the man.
17. The man's family has said that he had been involved in an earlier altercation with the first prisoner and the second prisoner in which the second prisoner had sustained injuries. There do not appear to have been any incident reports or statements taken at the time of this altercation.
18. There is also no available documentary evidence to suggest any action was taken by staff to monitor and resolve this apparent animosity between the two prisoners. It is not evident that either the man or the second prisoner were charged under Prison Rules or placed on anti-bullying procedures.
19. The first prisoner said that he went to the man's cell on Wednesday 13 April. The prison videotape showed that others went with him, including those who were also subsequently convicted. He denied having or using a weapon. He described a fight and his retreat. However, according to evidence heard at court, as the man came from his cell, fatally injured, he said, 'the first prisoner stabbed me.'
20. A second prisoner later convicted of the man's murder, told police in interview that he was present when the man died. But he too denied injuring the man.
21. A third prisoner gave what amounted to a 'no comment' interview to police. He was subsequently convicted of assisting an offender and sentenced to two and a half years imprisonment.

22. Whether or not the first prisoner and others told the truth at interview or during the subsequent trial, there can be little doubt that there was bad feeling between the man and the first prisoner. It is of concern that staff had not noticed or appreciated the level of animosity that was building up between the man and the first prisoner, and that no action had been taken to address the developing situation.
23. The Chief Inspector's report of her inspection of 11-15 April 2005 drew attention to the fact that anti-bullying policies and procedures were not widely understood by staff or prisoners. The pre-inspection focus groups of prisoners and staff found:
- Inexperienced staff group, high turnover, lack of training and more often than not victims of bullying from prisoners.
 - More staff and management presence needed on wings to make units safer. Staff bullied, and giving in to bullies. Prisoners controlling units. Staff seemed to have instructions to vacate the units if any trouble arose.
 - Two officers to 70+ prisoners not safe. Prison a time-bomb waiting to go off. Things not turned completely as prisoners liked the relaxed regime and did not want to be transferred out.
 - Personal officer scheme negatively affected by high staff turnover. Little contact with personal officers throughout sentence and reports written by unknown staff members.
 - Good atmosphere amongst prisoners on the units, though some bullying around the drug culture in the prison. Problems sorted out by themselves as can't rely on staff.
 - Sudden changes to atmosphere on wings depending on who got put on the wing. Safety was "in your own hands".
 - Drug and alcohol use rife and high presence of mobile phones (and knives) in the prison. Staff unable to cope with the situation, tended to ignore what was happening and no apparent direction from management on the issue.
24. The inspection report made four recommendations that I consider to be particularly pertinent in this case:
- Prison Custody Officers should be trained as personal officers. (HMCIP – recommendation 3.10)
 - All staff should be given refresher training on anti-bullying systems and the training database should show what proportion of the staff group has received such training and when. (HMCIP - recommendation 3.12)

- There should be systematic cross-comparison of injuries to prisoners, security information reports, self-harm incidents and adjudication results at anti-bullying and/or safer custody meetings. (HMCIP - recommendation 3.15)
- The Director should ensure that staff understand and are able to implement Rye Hill's anti-bullying procedures. (HMCIP - recommendation 3.17)

Staff witness evidence

25. A Prison Custody Officer, on duty in Davies Unit during the afternoon of 13 April, described an argument he had at about 1.30pm with the first prisoner, when he refused to allow him to go to another prisoner's cell to speak to him. He said that the first prisoner became angry and started shouting at him saying, 'Do I have to smash things up like that pussy hole (the man) to get things done?' The Prison Custody Officer considered this unusual as the first prisoner was usually 'a quiet person'. He thought that the first prisoner probably made the comment as he might have heard the man shouting at him about a telephone call concerning his forthcoming release from prison.
26. The PCO said that the man left the unit with others at about 2.00pm to attend a hygiene course, but he returned shortly afterwards with a certificate excusing his attendance on the course. The man was allowed to stay out of his cell as he had other duties helping to clean the wing during the afternoon.
27. The PCO said there were no other incidents of note during the afternoon. At 3.55pm he was in his office, sitting at his desk, talking by telephone to a member of the education department. His attention was drawn to raised voices which he assessed to be coming from the area of the unit near to its main entrance. He excused himself and terminated the phone conversation. The PCO entered the main body of the unit. As he did so, he saw the first prisoner. He noticed the first prisoner appeared to be in a hurry, unusually so, as he 'usually walked at a casual pace'. The first prisoner neither acknowledged the PCO nor looked in his direction.
28. The PCO looked to his right and scanned the area. The man appeared at the doorway to his cell. He was clutching the left side of his chest with his left hand. The Prison Custody Officer saw a red patch around the man's left hand. It had stained the t-shirt he was wearing. The man looked at him and moved back into his cell. The PCO thought the man wanted to avoid him. He walked towards the man's cell. Another prisoner, said, 'You need to get up there.' A PCO entered the man's cell and saw him clutching his chest. There was blood spillage on the cell floor. He made an urgent radio call. The man left the cell but made only a few steps before he collapsed on the floor. He was lying on his back.
29. The PCO and the other prisoner put the man in the recovery position. The other Prisoner spoke to the man who was drifting in and out of consciousness. Another PCO arrived and assisted with first aid. Rye Hill healthcare staff arrived promptly and took over. An air ambulance crew arrived and the doctor

performed emergency surgery and internal cardiac massage. Sadly, they were unable to save the man's life and at 4.50pm the doctor pronounced him dead.

Use of emergency call systems

30. HMP Rye Hill has a system in place for summoning emergency medical assistance. The coded system enables attending staff to be aware of the type of incident they are attending and therefore take the appropriate equipment.
 - 'Code 3' is used for minor injuries
 - 'Code 2' is for serious injuries
 - 'Code 1' is for an extremely serious incident such as a hanging or heart attack.
31. On finding the man standing near his television bench, clutching his chest through a blood stained t-shirt and with blood on the floor, the second PCO used his personal radio to call a Code 2 emergency. He then briefly left the cell, leaving the man alone, to let another prisoner back onto the wing.
32. When he returned, the man was on the floor outside the cell lying on his back. The PCO then pressed his first response button on his personal radio and tried to place the man in the recovery position. Staff then began to arrive to support.
33. Also working on the unit that afternoon was another PCO. He was heading towards the commotion when he saw the man covered in blood and returned to the office to summon assistance. As he reached the office to summon assistance, he heard the 'Code 2' call for emergency assistance and so pressed his first response button. The second PCO then grabbed some first aid equipment and returned to the landing.
34. The second PCO took the first aid box to the man, unwrapped some dressings and passed them to a prisoner to apply to the wound.
35. In light of the injuries the man sustained, it would have been more appropriate to have used Code 1 to summon assistance. However, as the man was initially walking out of his cell it is fully understandable why Code 2 was used. The personal alarms were also used which ensured that staff were present quickly. I do not believe that the outcome would have been different had a Code 1 been used.

Inspection by HM Chief Inspector of Prisons

36. At the time of the man's murder, the Inspectorate were undertaking a full unannounced inspection. This was a follow up to the first inspection held in 2003. The inspection report provides a picture of the culture and regimes that existed in April 2005. Following the inspection in 2003, Rye Hill had undertaken to put in place more effective management and support systems

but the unannounced inspection found that many of the key concerns had not been dealt with. The Chief Inspector wrote in the foreword to her report:

“... the prison had deteriorated to the extent that we considered that it was at that time an unsafe and unstable environment, both for prisoners and staff ... So great were the concerns that I immediately informed Ministers and urged the Chief Executive of the National Offender Management Service to take immediate and decisive action.”

37. The inspection team found evidence of mobile phones, and were told by prisoners of the ready availability of drugs and weapons. This was supported in evidence given to the police and heard at the trial when it was alleged that drugs, hooch, and mobile phones were commonplace. One of the accused men admitted to the use of and ready access to drugs in Rye Hill.
38. Another area of concern was the profile of the staff group. The inspectorate found that 30 per cent of Prison Custody Officers had been in post less than six months. There was a 40 per cent attrition rate of staff, and many who remained worked away from the residential areas. The inspectorate also found that managers were not visible on the units. All this led to an inexperienced group of staff working on the residential units, ill equipped to deal with prisoners who often knew the prison system better than they did.
39. The experience of the first and second Prison Custody Officers confirms this. The first PCO had only begun his training as a custody officer in November 2004 and had qualified just three months prior to the man's murder in January 2005. The second PCO had only worked on Davies wing four or five times prior to the events of 13 April.
40. In her report of the unannounced inspection, The Chief Inspector wrote further:

“We were impressed by the enthusiasm and keenness of [the] officers, and their positive approach to their task and to prisoners; but this alone did not equip them to set and enforce the proper boundaries. Nor did it enable them to answer questions and complaints from prisoners, many of whom knew the workings of a prison better than the staff. This in itself caused considerable frustration among prisoners and generated anger and abusive language towards staff. Moreover, it was evident that some critical systems, such as suicide prevention and personal officer work, were suffering because staff were unable, or did not know how, to engage with either prisoners or the appropriate systems.”

41. The inspectorate report included a total of 89 recommendations.

Cell Searching and Accommodation Fabric Checks.

42. My first investigator undertook a review of the cell searching records for the units over the three months beginning April 2005. At that time, although the

records were complete, he judged that some details appeared less than accurate:

- They showed the same officers doing different searches in various cells at the same time on the same date.
 - The record of items found was almost always nil. With searches being undertaken by staff from the dedicated search teams, the first investigator would have expected more to have been discovered.
 - The search record documentation appeared to have been completed away from the search area, and on many occasion it was repetitious and almost duplicated.
43. Over the months of May and June, an improvement was seen with more items being found and better records being kept. It was noticed that officers appeared to work in the same teams (pairs) over all three months. The first investigator felt a change of teams would be beneficial, coupled with regular monitoring of searches and procedures by their managers.
44. A review of the records of Accommodation Fabric Checks (AFCs) revealed that some of the units were not completing their required daily security checks on the cells. A check of a period of four days showed AFCs supposedly completed, but not signed for, along with many units having no management checks completed for the full four days.
45. The first investigator arrived on one unit at 2.30 pm and asked what would happen given that no checks at all had been completed for the day and, more importantly, the record of the morning tasks had not been filled in or signed for. The reply was, "They will be filled in by tonight as always." The first investigator then asked if the tasks would be completed or if the record would just be signed. The answer was, "The record would just be completed because that's what is wanted. That's the way it is."
46. Records are an important tool of communication to ensure continuity of care. The standards of record keeping at that time fell far short of what is acceptable. This was further highlighted by the lack of an audit trail showing the location of the man's latest prison records after his death. Whilst I make no formal recommendation about records and record keeping, I trust that GSL management have now put in place systems to ensure effective, timely and appropriate record keeping is in place.
47. However, the same poor practice was not shown on every unit. On Farley Unit, The first investigator found the records to be up to date, well kept, and containing useful comments.
48. It is essential that management checks are regularly undertaken to ensure that the Accommodation Fabric Checks are undertaken in accordance with agreed searching procedures and in a timely manner. The Director will wish to ensure that an auditable system of management checks is implemented to monitor the quality, nature and frequency of essential security monitoring.

Clinical Review

49. The clinical review conducted by my Deputy Ombudsman, shows that the man was 44 years old and healthy. She concludes that the man's medical treatment was appropriate throughout his sentence. On the day he died, staff and the air ambulance crew went to 'extraordinary lengths' to try to save his life. She makes no recommendations regarding the man's clinical care.

CONCLUSIONS

50. The man's was well versed in the ways of prison. He capable both of being aggressive and assertive and of being constructive and thoughtful in the way he conducted himself. He would have made some friends and some enemies within the prison's population, and I think it may be fairly said he would probably guard his reputation of being able to stand up for himself.
51. Rye Hill's prisoners are serving long sentences, including life imprisonment, for mainly violent offences. Furthermore, many have reputations as men to be reckoned with. In contrast, many staff are inexperienced and, at the time of the man's murder, were not well-led by their managers. They were often unsure about what to do when those prisoners who made the loudest demands appeared to carry the day. At the time of the man's murder, a criminal sub-culture was embedded at Rye Hill. It was against this backdrop that the he was murdered.
52. Given the circumstances outlined earlier (including the effect of the Rectification Notice imposed on the contractor, GSL), I make no formal recommendations of my own in this report. However, I draw particular attention to the following recommendations made by the Chief Inspector of Prisons after her unannounced inspection of April 2005:

The Office for Contracted out Prisons (OCP) should take urgent action to reinforce staff and management at Rye Hill to ensure the safety of prisoners and staff. (HMCIP - recommendation 3.2)

The Office for Contracted out Prisons ((OCP) should review staff recruitment, retention, deployment and management at Rye Hill. This must include:

- risk assessments of safe staffing levels, in relation to the current staff and prisoner profile
- mechanisms to ensure a visible and experienced management presence on all residential units
- additional staff training and support
- analysis of recruitment and retention patterns and action to address staff turnover. (HMCIP - recommendation 3.3)

All staff should be given refresher training on anti-bullying systems and the training database should show what proportion of the staff group has received such training and when. (HMCIP - recommendation 3.12)

There should be systematic cross-comparison of injuries to prisoners, security information reports, self-harm incidents and adjudication results at anti-bullying and/or safer custody meetings. (HMCIP - recommendation 3.15)

The director should ensure that staff understand and are able to implement Rye Hill's anti-bullying procedures. (HMCIP - recommendation 3.17)

Residential managers should be a regular presence on the wings while prisoners are unlocked, to support staff and provide on-the-job training. (HMCIP - recommendation 3.57)

ANNEXES

1. Report of an unannounced inspection of HMP Rye Hill 11 -15 April 2005
2. Clinical review
3. Review of cell searching and Accommodation Fabric Checks
4. Documents considered during the investigation