The death in custody of a man in HMP & YOI Doncaster in April 2004

Report by the Prisons and Probation Ombudsman for England and Wales

December 2005

FOREWORD

The sad death of this man occurred during the first weeks after I took responsibility for investigating all deaths in custody. At the outset I would like to offer my sincere condolences to the man's family on their loss. He was only 20 years old. Tragically his death appears to have resulted from an accidental heroin overdose and came at a particularly difficult time for the family so soon after the death of his uncle and his grandmother.

Under transitional arrangements agreed with the Prison Service at the time, a Senior Investigating Officer (SIO) was appointed by the service to conduct the investigation. The SIO works to me for the duration of the investigation and submits a draft report that I review and amend as necessary. This final report is my independent examination of the circumstances leading to the man's death.

One of my family liaison officers met the man's family and remained in telephone contact with them throughout the investigation. A clinical review into his care and treatment was commissioned from Doncaster Central Primary Care Trust (PCT).

Doncaster is one of several prisons that are managed by private companies on a contract basis. The contract to manage Doncaster is held by Premier Prison Services and a parallel investigation into the man's death was conducted by their investigation officer. I have read the report of this investigation and his conclusions do not differ in any way from my own.

I would also like to thank Global Solutions Ltd for their report into the man's care and management at court.

This version of my report has been anonymised for publication on my website. The annexes listed below are not published in anonymised form.

Stephen Shaw CBE
Prisons and Probation Ombudsman **December 2005**

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SUMMARY

This is a report into the death of a 20 year old man in HMP & YOI Doncaster on 21 April 2004. The issues in this summary are revisited in greater detail in the main body of the report.

The man arrived at Doncaster prison on 27 January 2004. He was transferred to Hull prison on 30 January and returned to Doncaster on 16 March. For about a month before his death he shared a cell with another prisoner. The man was serving a sentence of 2½ years but was also awaiting sentencing on another matter.

The man had served three custodial sentences prior to the one he was serving when he died. Although he was at various times judged to be at risk of self harm and had self harmed in the past, there is no record of him self harming while in prison.

The man had a history of drug abuse going back to his early teenage years. At the time of coming into custody in January 2004 he was reportedly spending £50 a day on heroin. It seems likely, however, that he had not used any heroin between 27 January and 20 April 2004.

The man's grandmother died on 11 April 2004. His request to attend her funeral was not granted by Doncaster prison. His grandmother's funeral was held on 20 April. By coincidence this was the same day he appeared in court on a further charge.

On the morning of 20 April 2004, the man was taken to Leeds Magistrates Court. He returned to Doncaster prison later that day and was taken back to his cell at about 8.30pm.

A number of prisoners, including the man's cellmate, say that shortly after the man was finally locked in his cell he smoked what they believed to be heroin that he had obtained at court that day.

The following morning wing staff checked the roll and started unlocking cells as normal. The man's cellmate got up, went to breakfast, returned to the cell, changed into PE clothing and went to the gymnasium leaving the man apparently asleep on the top bunk.

At approximately 8.12am, a Prison Custody Officer (PCO) entered the cell. The PCO was immediately concerned about the man's condition and summoned medical assistance. Locally employed nursing staff and then NHS paramedics attended the scene and made efforts to resuscitate the man. These were unsuccessful and the man was pronounced dead at the scene by a paramedic from the South Yorkshire Metropolitan Ambulance Service at 8.31am.

The cell was then sealed and the prison followed agreed procedures in relation to notifying the police, next of kin, the coroner and other agencies.

The prison carried out a search in case more heroin was available on the wing and drug tested the man's co-defendant. They did not test his cellmate.

The toxicology report showed extremely high levels of total and free morphine in the man's body. The cause of death is listed as heroin poisoning.

The investigation into the man's death has revealed some weaknesses in interdepartmental communications at Doncaster prison and there is a need to ensure clarity when dealing with requests to attend family funerals.

Other prisoners gave evidence that the man told them that he obtained the heroin "from a friend at court". The man's father phoned the prison on 19 July 2004 and said that he had found out who had passed the heroin to his son and when. He gave a name and said that the drug had been given to his son at court on 20 April. This information has since been passed to the police and I believe they have interviewed the man in question. This inevitably raises concerns about security and searching procedures at both Leeds Magistrates Court and in Doncaster prison's Reception area.

Some prisoners have shown a surprising lack of awareness of the dangers in smoking heroin and the danger signs of possible overdose. In particular there is some ignorance about the possible effect of taking heroin following a period of withdrawal.

Those members of staff who attempted to revive and resuscitate the man acted promptly and professionally. From the evidence, it seems that by the time he was discovered it was too late to save him.

I make a number of recommendations at the end of this report, with the aim of helping to address some of the issues identified above.

PART ONE

1. BACKGROUND

HMP & YOI DONCASTER

HMP & YOI Doncaster is a large and modern establishment. Built by the public sector in 1994, its management is contracted out to Premier Prison Services. The prison holds up to 1,120 male prisoners with both adults and young offenders amongst the population. Doncaster is a 'local' prison serving courts in the Yorkshire area. Some prisoners are sentenced and awaiting transfer to 'training' prisons but most are unconvicted or unsentenced and are awaiting the outcome of court hearings.

The prison provides facilities to address a variety of issues faced by prisoners including substance abuse, resettlement issues and health issues. Counselling and support services are available to those prisoners who may need them.

On 21 April 2004, the prison held a total of 1,082 prisoners of whom 822 were adults and 260 were young offenders.

2. THE EVENTS SURROUNDING THE MAN'S DEATH

The man was remanded into custody at Doncaster prison on 27 January 2004. He had been convicted of burglary offences but was awaiting sentence. The man's co-defendant on the burglary charges was already in custody at Doncaster.

The man went through the normal induction, reception and screening processes. During this process it was identified that he was using heroin and that he had been the subject of F2052SH procedures on previous sentences. The man commenced a detoxification programme on 28 January.

On 30 January, the man was transferred to HMP Hull. He stayed at Hull until 16 March when he was taken to Leeds Crown Court and received sentences totalling 2 years and 174 days. This sentence took into consideration the unexpired portion of his previous sentence. From court, the man was returned once again to Doncaster.

On 24 March, the man was taken to Pontefract Police Station to be interviewed about and arrested on a charge of attempted robbery. He returned to Doncaster that same evening.

On 11 April, Doncaster were informed of the death of the man's grandmother. As is usual practice, the information was passed to the prison Chaplain. The man was called to the Chaplaincy department the following day and the news was broken to him in private there. The Chaplain seems to have been unaware that he had already had the sad news during a visit from his father the day before. The Roman Catholic Chaplain spent about an hour with the man during which the man spoke to his mother on the telephone for about 20 minutes.

The man was seen twice more by the RC Chaplain during that week to talk about the arrangements for his grandmother's funeral. He was advised that it was unlikely that he would be able to attend because his grandmother had not acted 'in loco parentis' and was therefore not regarded as a close relative. Under Prison Service Instruction to Governors 36/1995 prisoners are only allowed to attend the funerals of close relatives. Grandparents are not deemed to be close relatives unless they have acted 'in loco parentis'.

The funeral was held on 20 April and the man did not attend. In any case, coincidentally, he was due to appear at Leeds Magistrates Court on the charge of attempted robbery.

On the morning of 20 April, the man was taken to Reception for his court appearance. Staff say he appeared bemused and told them that he had not thought he needed to attend court for the hearing that day. At 8.00am, the man was collected by Global Solutions Ltd (GSL) Court Services and taken to Leeds Magistrates Court. The Prisoner Escort Record (PER) suggests that he spent his day at court in a routine fashion and a subsequent investigation by GSL has not revealed anything of note either. However, interviews with

other prisoners and later information received from the man's father suggest that, while he was at court, he received a bag of heroin which he later took with him into his cell at Doncaster prison.

The man arrived back at Doncaster that evening. He went through the reception procedures and was taken to his cell on A wing. When he arrived on A wing, he was seen and spoken to by at least two other prisoners who enquired how he had got on at court. One was his co-defendant who said that the man had told him he expected to get a further three years and had seemed "wounded". Another prisoner said that when he asked the man how he was the reply had been mumbled and he did not catch what was said.

Once inside cell 111, the man spoke to his cellmate who also asked him about his court appearance and recalled the man saying he expected two and a half years. The cellmate felt the man had seemed "OK " about it. The cellmate also said that the man asked the officer who escorted him to the cell about his canteen goods. Earlier in the week, the man had placed an order for such things as tobacco, toiletries and snacks to be purchased from his private cash. The goods should have been delivered that day but the man was at court and was therefore concerned about what had happened to them. The officer went to find out. The cellmate said that, during the officer’s absence, the man took a cellophane package from his pocket and put it on the cell window sill. He described it to the cellmate as "a bag". The cellmate said he could see that it contained a white powder that looked like heroin.

The officer returned shortly afterwards to say that the canteen goods had been locked away for safe keeping and could not be dealt with until the following day. Once again, the cellmate described the man as seeming "OK" about this.

The cellmate said that, almost as soon as the officer left for the second time, the man took the foil lid from a Pot Noodle container, spread the powder onto it and began smoking it by inhaling the smoke through a biro tube.
The cellmate said that the man fell asleep after smoking the heroin. The cellmate turned the cell light off at about 10.30pm and also eventually went to sleep. He said the night was uneventful. The cellmate recalled waking up and opening the cell window at some point but that is all.

Staff carried out a roll check at approximately 6.00am. They do this by opening the cell observation flap and counting the number of prisoners in each cell. It is sufficient to see a person in bed asleep.

After waking those prisoners who had to be up early for court appearances or to work behind the servery, the staff then began unlocking the other cells on the wing for breakfast. Prisoners are not required to go for breakfast if they do not wish to. Cell 111 was unlocked in turn. The cellmate who had got up and dressed went downstairs for breakfast, leaving the man on the top bunk in the cell. The cell door would once again have been locked. At this time the cellmate said that he had noticed that the man had some bluish blotches on his face and some hardened froth around his mouth. While he was at

breakfast, the cellmate said he spoke to other prisoners about the man’s condition. Another prisoner said he went to the door of cell 111 and called out to the man but got no response.

After breakfast the cellmate returned to the cell and changed his clothing to go to the gymnasium. Once again, he said, he assumed the man was asleep and did not speak to him or try to rouse him. The cellmate went to the gymnasium about five minutes later and did not return to the wing again until after the discovery of the man’s death.

At around 8.10am, a Prisoner Custody Officer (PCO) went to the man’s cell. Part of the PCO’s duties involve taking voluntary drug tests from prisoners who have joined a programme designed to help them stay off drugs. The man was a participant in that programme and had had one such voluntary test on 8 April. This test had proved negative.

The PCO had been an officer on the healthcare unit for eight years and has a NVQ level 2 in Direct Care Nursing. The PCO said he found the cell door ajar. He said he called out to the man twice with no response. He went up to the man, who was on the top bunk, and felt his neck for a pulse. He said he could find no pulse at either neck or wrist and the man felt cold.

3. POST-INCIDENT RESPONSE

Prison records show that the PCO raised the alarm at 8.12am. He called for medical assistance on his radio from just outside the cell and then went back inside where he was joined within a minute by two other PCOs. All three men lifted the man from the bunk and were about to commence resuscitation when they were joined by a nurse.

The nurse said he too took the man's pulse and could find none. He said the man was very cold and there were extensive blue patches on all of his visible skin. He said he was joined almost immediately by another nurse, and she started chest compressions while he gave the man mouth to mouth.

During the attempted resuscitation, the first PCO tried to use an oxygen bottle but found it difficult to release the gas. He told the first nurse that he was having problems and he looked up quickly and said that the bottle must be empty. A second bottle was produced but not used as mouth to mouth was continued. Later it was found that the original bottle was in fact full and there was a second valve which had not been opened to release the gas.

The first nurse said that, after about three minutes, another nurse took over mouth to mouth and he ran to get the defibrillator machine. The interactive reading on the defibrillator registered no response or heart movement and indicated that resuscitation should continue. Staff carried on with the chest compressions and mouth to mouth until ambulance paramedics arrived on scene at approximately 8.26am. The paramedics applied their own heart monitor but received no response. They advised the nursing staff to stop their

attempts at resuscitation at 8.31am. Some five minutes later the prison doctor arrived and confirmed that the man was dead.

The Anglican Chaplain, entered the man's cell and said a prayer for him. The cell was sealed at 8.53am. The police arrived at and took pictures between 10.42am and 10.48am and at 1.58pm the man's body was taken to the mortuary. There was no suicide note.

4. WHAT OTHER PRISONERS SAID

Several prisoners were interviewed or made statements during the course of the investigation.

The cellmate said that after smoking some of the powder the man lay on the bed. He was pale and his eyes were red. He gave the man tobacco and papers and the man smoked some of the cigarette before going back to the powder. At one point the man looked in the mirror and said “I’m fucked” or "fuck it" and then started smoking the powder again. The cellmate said that while the man was smoking other prisoners were asking him to give them some. He said that the man smoked most or all of the powder before passing the foil under the door. The man’s actions never gave the cellmate any real cause for concern. There was no indication or implication that the man wanted to overdose on heroin. The cellmate said he turned the light out at 10.30 or 11pm. The man was breathing very heavily and it took him a while to get to sleep. At some point he said he got up to open a window and said he thought that the man had stopped making the heavy breathing noises. The next morning the cellmate did not try to rouse the man or talk to him. He said he thought he would be sleeping off the effects of the drug. He did notice some bluish blotches on his face and some hardened froth around his mouth. He said he was unaware of the man's death until told later that morning by the Houseblock Unit Manager.

The cellmate also said that he had seen the man crying on the Sunday that his grandmother died. He thought the man had been "clean" between 27 January and 20 April 2004 and that he was "OK" about the prospect of a further sentence. The cellmate said that the man told him he had obtained the heroin at court on 20 April.

The man's co-defendant was also interviewed. His view was that the man did not cope well with being in prison. He said he thought that the man had not been unduly saddened by his grandmother's death, nor had he expressed anger or disappointment at not being allowed to go to the funeral. He said that the man had a "pretty bad" drug habit before coming into prison. The co-defendant said that the man had seemed "wounded " at the prospect of a further sentence. The co-defendant denied any knowledge of any talk of drugs outside the man’s cell on the evening of 20 April. He said that prisoners had congregated outside the man's cell because that was where the ironing board was set up.

Another prisoner said that the man was upset but coping with his grandmother's death. He said he had seen the man smoking heroin on the evening of 20 April and that the man had told him he obtained the heroin at court. The next morning he said the cellmate had told him at breakfast that the man looked a funny colour and was looking "rough". They went up to the cell and shouted through the door. When there was no response they assumed the man was "out of it". The prisoner said he did return to the cell a short time later but did not go in and shouted to the man instead. Shortly afterwards the PCO had entered the cell.

Other prisoners spoke as follows:

One said that he had seen the man "as high as a kite" on the evening of 20 April. He also said that the co-defendant tried, but failed, to persuade the man to give him some of the heroin.

Another said that he was aware of the co-defendant trying but failing to get some of the heroin from the man on the evening of 20 April.

A third prisoner said that in a conversation with other prisoners on 21 April he had learned that the man had said that he obtained the heroin at court.

A fourth said that the man had been 'quiet' and that he thought this was due to his grandmother's death and not being allowed to go to the funeral.

5. DONCASTER PRISON'S RESPONSE TO THE DEATH OF THE MAN'S GRANDMOTHER

The prison received notification of the death of the man's grandmother at 4.24pm on Sunday 11 April 2004.

The man also received a visit from his father on Sunday 11 April. During that visit he told his son of his grandmother's death.

The Roman Catholic Chaplain saw the man on 12 April. He spoke to him for the best part of an hour and let him make a phone call to his mother. He also arranged to see him again to provide support and to check on funeral arrangements.

During those subsequent meetings, the man was told that it was unlikely that he would be allowed to go to the funeral because his grandmother's relationship with him did not constitute in loco parentis. He was offered a service in the chapel on the day of the funeral but does not appear to have asked for this. Prison Service guidelines describe a close relative as husband or wife, brother or sister, parent or child or somebody having an 'in loco parentis' relationship with the prisoner.

The RC Chaplain said that he told the man the final decision on whether he could go to the funeral rested with the prison Director and that his application

to attend would be passed on once the funeral arrangements were known. It is unclear when the funeral details were available to the prison. It is most likely that the man was told of the arrangements in a phone call with his mother in the Chaplaincy on 16 April. What is certain is that the necessary form was never passed to the Director for a final decision. Whilst the man would, as a result of the RC Chaplain's advice, have been fairly sure that he would not be allowed to attend the funeral, he had not had a final refusal and may have been left with some lingering hope. Certainly he does not seem to have conveyed a message to his parents that he would not be allowed to go to the funeral. Neither does he appear to have been aware that he was supposed to go to court on the day of the funeral.

After his visit on 11 April, the man’s father wrote to the prison Director to request his son’s attendance at the funeral. The man’s father faxed his letter to the prison on the same day. When, after a few days, there had been no reply, the man’s father telephoned the prison and was eventually told that his son could not attend the funeral.

On Monday 19 April, the man’s father telephoned the prison to express his disappointment and was put through to the Anglican Chaplain. They discussed the reasons for the refusal.

The man’s father’s fax of 11 April was not registered in the Director’s office until Monday 19 April. A reply, dated 20 April, confirming the fact that the man would not be allowed to attend was prepared but not sent due to the man’s death.

On 20 April, following the funeral, the Anglican Chaplain phoned the man’s mother. He agreed to arrange for the man to be able to call his mother once he got back from court that evening. The Anglican Chaplain went to the wing and left a message with the Houseblock manager who agreed to pass it onto the evening shift who came on duty at 7.00pm. This he did but, for some reason, the message was not acted upon and the man was not offered a call to his mother on his return from court.

The man’s father called the Anglican Chaplain at about 9.00am on the morning of 21 April to find out why the call had not taken place.

6. THE PRISON SERVICE’S ASSESSMENT OF THE MAN’S RISK OF SUICIDE OR SELF HARM

The man’s history is well documented within his prison records and in a pre-sentence report prepared by a probation officer who saw him in Hull prison, dated 1 March.

Records show that the man had self harmed on two previous occasions, neither of them in prison. As stated earlier, the man had been subject to F2052SH procedures on a previous sentence at Doncaster. The man told staff who escorted him from Wakefield Magistrates Court to Doncaster on 27

January that he might be at risk of self harm. They completed and handed over a suicide/self harm warning form to the reception staff at Doncaster. When questioned by the healthcare staff at Doncaster, the man again spoke about his history of self harm as well as the fact that he was taking anti-depressants and was feeling depressed at the time. He also said, however, that he did not feel like hurting himself or killing himself. He was assessed as not having any thoughts of self harm or suicide and was not put on a watch. He was, however, put onto a detoxification programme with effect from 28 January.

When the man was transferred to Hull prison on 30 January, the staff there noted that he had a history of self harm and that he was upset at his grandmother's illness. They did apply F2052SH procedures but decided to close the F2052SH booklet and cease the special supervision when they reviewed the situation five days later.

On 16 March, the man appeared at Leeds Crown Court and was sentenced to two and a half years imprisonment. The duty Probation Officer at court sent an urgent fax to Doncaster drawing attention to the man's history of self harm. Attached to the fax was a copy of the pre-sentence report mentioned above, which included an assessment of the man as being at high risk of self harm. This fax was received and considered in Doncaster's healthcare department. Their assessment after seeing the man was that he was relaxed, he had not self harmed for nearly two years and that no watch was needed at the time.

The healthcare department also saw the man on 11 April after his father had told him of his grandmother's death. He said he was upset but stated he had no intentions of self harm. He said he got on well with his cellmate and was allowed to return to the wing.

On 12 April, he was seen by the RC Chaplain who let him call his mother and offered to arrange a referral to prison healthcare. The man declined this offer preferring instead to go back to his cell on the houseblock. He had further meetings with the RC Chaplain on 13 and 16 April about funeral arrangements and for general support. On each occasion the RC Chaplain said that the man was asked whether he wished to go to the healthcare centre. On each occasion, the man said that he was fine, that he had a good cellmate and that he just wanted to go back to his cell.

Despite being told that he would not be able to go to his grandmother's funeral the man seemed to be coping well and remained outwardly cheerful. The RC Chaplain recalls seeing the man on the evening of 19 April when he was with "a group of lads and very jolly ".

The RC Chaplain was not aware of the man's history of self harm and was not concerned that he might be at risk of self harm. He did not think special watch procedures were appropriate as a result of his talks with him.

As noted in the previous section, the Anglican Chaplain spoke to the man's mother on the day of the funeral. The man's mother has said that during this

conversation she suggested that the man should be put on a suicide watch. When interviewed, the Anglican Chaplain said that he did not remember her saying this specifically.

7. LIAISON BETWEEN DONCASTER AND THE MAN'S FAMILY

The initial contact with the man's family was as a result of the death of his grandmother. It is clear that the man's family, and his father in particular, were frustrated at what they saw as a poor response from the prison to their requests for the man to attend his grandmother's funeral.

On the day of the man's death, the prison at first contacted West Yorkshire police with the intention that they should break the news to the man's family. When it appeared that this might not happen immediately the Director asked the Anglican Chaplain to do so. The Anglican Chaplain contacted the Catholic priest who had conducted the man's grandmother's funeral and they set off together. The Anglican Chaplain and the priest were held up in traffic and did not arrive at the family home until about 12.30pm. They found that the police had arrived at 11.00am and broken the news to the man's family.

The Anglican Chaplain spent some time with the family giving what information he could about the circumstances of the man's death.

On 26 April, five days after the man's death, the prison Director wrote a letter of condolence to his mother and father. This letter was also partly in response to a letter dated 22 April to the prison from the man's father and mother in which they had posed a number of questions about the circumstances of their son's death. The letter was addressed to the father's address in Castleford rather than the Wakefield address of his mother. This may explain why, at a later date, the man's mother said she had not had a letter of condolence. When the prison Director was made aware of this, a second letter was immediately sent to the Wakefield address.

The man's family visited the prison on 27 April. They met with the Director and the RC Chaplain. During the visit they went to the man's cell, lit a candle and said a prayer in the prison chapel. They were also able to take away with them the man's clothing and personal effects. The visit was reported to be very positive.

The prison Director and RC Chaplain attended the man's funeral. Since then the RC Chaplain has contacted the man's mother by telephone.

8. THE FAMILY'S VIEW

One of my Family Liaison Officers visited the man's mother, father, step-father and uncle on 24 May at the man's mother's home. The family was concerned that the man had not been put on a suicide watch on his return from court on 20 April. His mother felt that the death of his grandmother combined with his court case would have affected the man greatly. They were also concerned

that the man's cell mate had not been given a drug test. The man's mother described him as a generous, loving and sensitive person. She said that she had received several letters of condolence from other prisoners.

PART TWO

1. FINDINGS & CONCLUSIONS

The man died after smoking heroin on the night of 20 April 2004.
Numerous prisoners have described seeing the man smoking what he told them was heroin that night. He had been a regular and heavy user of heroin up to 27 January but had probably not used any between that date and 20 April. The man's tolerance to heroin would have been greatly reduced if he had not taken any drugs during those 12 weeks. The man smoked a large amount of heroin but there is no indication that he had an intention to overdose on it, nor to end his life.

It seems likely that the man obtained the heroin whilst appearing at Leeds Magistrates Court on 20 April 2004
Several prisoners have said that the man told them that the heroin was given to him at court on 20 April. The man's father has since provided information to the prison that appears to confirm this account. The police have since interviewed a man in connection with this allegation.

The requests for the man to attend his grandmother's funeral should have been handled more effectively
It may have been unclear to the man whether the opinion offered by the RC Chaplain that he would not be allowed to attend the funeral constituted a final decision by the prison. The procedure for obtaining a firm decision by the Director was not implemented correctly.

The request from the man's father on 11 April was mishandled and led to confusion and anger. The written reply was not sent because it was overtaken by events.

The on-going assessment of the man's risk of suicide or self harm was managed correctly.
Assessments took place at appropriate times and took account of past history as well as current risk factors. There is evidence that the man was offered the opportunity to speak to healthcare staff on more than one occasion after the death of his grandmother. He was allowed to make two private phone calls to his mother.

It is very regrettable that he was not offered a call to his mother on 20 April on his return from court. This request was passed on by both the chaplain and the houseblock manager but was not acted upon by staff on duty that evening.

With one exception, the immediate response to the incident was good.
The response of those staff who attempted to revive the man was prompt and sustained for a significant period of time. They are to be thanked for their efforts in what must have been very distressing circumstances.

There seems to have been some confusion about the correct operation of the oxygen cylinders.

2. RECOMMENDATIONS

1. The relevant sections of this report concerning the passing of heroin at court should be brought to the attention of staff at Leeds Magistrates Court.

2. A review of searching procedures designed to prevent the smuggling in of contraband by prisoners into Doncaster prison should be carried out.

3. Doncaster should review its procedures in respect of requests to attend funerals. Requests must be passed to the Director in a timely manner. All interested parties should be kept in touch with the progress of funeral requests.

4. Drug awareness advice to prisoners should include information to make them more aware of the potential for overdosing through reduced tolerance. Information on the dangers of smoking heroin and the signs of overdose should be available to all prisoners and displayed on residential units.