

**Investigation into the circumstances
surrounding the death a man
at HMP Pentonville on 19 June 2007**

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

September 2008

This is a report into the circumstances of the death of a man at HMP Pentonville on 19 June 2007. Prison staff discovered the man hanging from the window bars of his cell, behind furniture he had moved to shield himself from view. Despite staff attempts at cardio pulmonary resuscitation and the attendance of paramedics, he was pronounced dead shortly after 6.25am. At his death, he was 25 years old.

I offer my sincere sympathy and condolences to the man's family and friends for their loss.

The investigation was carried out on my behalf by my colleague. A clinical review of the man's healthcare at HMP Pentonville was conducted by Islington Primary Care Trust. I am grateful for their comprehensive review.

I would also like to thank the Governor of Pentonville and his staff for their co-operation and assistance with this investigation. Particular thanks go to the Deputy Head of Prisoner Care, for his help throughout the investigation process as liaison officer.

The man had been at HMP Pentonville for seven months. In May 2007, he received four life sentences with a recommendation that he serve a minimum of ten years. The nature of the offences he had carried out, his inability to understand why he had committed them and their incompatibility with his faith, and the implications of the life sentences, all appeared to weigh very heavily on him. A month before being sentenced he had told a psychiatrist that he expected a life sentence, adding "this is what I deserve but it does make me feel what is the point of carrying on." Two months after being sentenced, on a night when his cellmate unexpectedly did not return from court, the man appears to have taken his own life.

I make eight recommendations, primarily covering healthcare procedures. I also highlight three examples of good practice.

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SUMMARY

The man was born on 18 February 1982. He died on the morning of 19 June 2007 at the age of 25 years in HMP Pentonville.

Between 2000 and 2006, the man had served three terms of imprisonment, each time re-offending shortly after release. On 8 December 2006, he was charged with several serious offences and remanded into custody at Pentonville.

On 28 February 2007, the man moved to the Vulnerable Prisoners' Unit on D1 landing. The reason for this move is not documented in his prison records. However, a cellmate said that he thought it was to do with an incident that had occurred while the man was still in the community. On four or five occasions when he was on D1, the man spoke to a Listener. He told both the psychiatrist and probation officer who prepared reports for the court that he could not explain why he had committed his offences. He also said that he wanted to take courses to understand his behaviour.

On 18 April, when staff learned that the man had received sad news from home, they arranged for him to talk to the prison Imam. The Imam organised a telephone call so that the man could talk to his partner in an office rather than having to use a telephone on the landing.

The man was sentenced to four terms of life imprisonment on 23 April 2007 with a recommendation that he serve a minimum of ten years before being eligible for release on licence. When he returned to Pentonville, the doctor in reception opened an ACCT plan to give the man the additional support he needed. The man spent some time talking to the Imam and then appeared to become brighter in mood. The ACCT was closed at the first case review meeting which took place on 25 April.

On his return from being sentenced, staff had moved one of the man's friends into his cell. The two men were cellmates until the man's death and they sometimes spent all night talking. On 18 June 2007, the cellmate went to court and, unexpectedly, did not return that evening.

When staff carried out the roll check at 5.30am the following morning, they could not see the man in his cell as there was a line of furniture in the middle of the room. They went into the cell and found the man hanging from the window bars behind the furniture. Staff and paramedics attempted to resuscitate him, but sadly they were unsuccessful.

A governor and family liaison officer visited the man's family to break the news and offer them help. They continued to support the family through the funeral and beyond.

My report includes eight recommendations and draws attention to three examples of good practice.

THE INVESTIGATION PROCESS

1. The man died on Tuesday 19 June 2007. My investigator opened the investigation two days later when she visited the prison. She met the deputy governor and with representatives of the Independent Monitoring Board and the Prison Officers' Association. She saw the man's cell in D wing and walked around the Vulnerable Prisoners' Unit. She was given copies of the man's prison records.
2. The investigator and clinical reviewer separately interviewed staff and prisoners who had been involved with the man during his time at Pentonville. My investigator also spoke by telephone to his probation officer.
3. One of my family liaison officers spoke to the man's mother and his partner to ask if the family had any concerns that they wanted to be included in the investigation. My investigator and family liaison officer visited the man's sisters and mother, at which time the family raised a number of issues. I hope that this report goes some way to answering their concerns.
4. .

HMP PENTONVILLE

5. HMP Pentonville is a category B local prison, principally serving the eastern and north eastern parts of Greater London. It holds unconvicted, unsentenced and sentenced adult males and has an operational capacity of 1,152 prisoners. Opened in 1842, the four original cellblocks remain in use but have been refurbished. There are now seven residential wings and a new healthcare unit.
6. Pentonville remains one of the busiest and most overcrowded prisons in England and Wales. It receives a high number of prisoners directly from the local courts, and staff have constantly to manage population pressures. Reception staff process anything from 60 to 100 prisoners per day.
7. A Samaritans supported Listener scheme is in place for prisoners who are in distress or crisis and need to talk in confidence. Listeners are prisoners who have volunteered for the role and have been trained by the Samaritans.

Healthcare

8. Pentonville's healthcare centre is a purpose built facility, separate to the main prison. Opened in 2005, the centre offers 32 in-patient beds and a primary care clinic designed to mirror a community GP practice. During an inspection in 2006, HM Chief Inspector of Prisons, Ms Anne Owers, found that medical staff were still undertaking unnecessary tasks, and not all GPs had received adequate induction to prepare them for working in a prison setting.

KEY FINDINGS

9. On 6 December 2006, the man was arrested and charged with several serious offences. At a very early stage in the process he confessed to the investigating officers and asked them to pass on his apologies to his victim. On 8 December 2006, at Waltham Forest Magistrates' Court, he was remanded in custody to HMP Pentonville.
10. All new prisoners go through the reception process and then move to the first night centre for a two day induction. A duty member of the healthcare staff assessed the man as fit for ordinary location and did not refer him to the doctor. An induction officer interviewed the man and then completed the Cell Sharing Risk Assessment (CSRA) and the first night interview and checklist. He recorded that the man would prefer to share a cell with another Muslim prisoner if possible. When he asked the man how he felt about being in prison, the man replied, "angry". However, when asked whether he had ever thought about or actually harmed himself, the man said that he had not. The induction officer also recorded that, when the man was asked what he did when he felt depressed, he said that he prayed. The induction officer then explained the support that was available from wing staff, the Samaritans and Listeners.
11. The man did not attend his second reception screening scheduled for 10 December. The nurse noted in his medical record that he refused to get out of bed and would not talk to her. When induction finished, the man moved to a cell on the level four landing on A wing where he remained for almost three months.
12. During his induction period, the man met the Imam. The man regularly attended Friday prayers at the mosque. He joined the study circle and often asked questions. He also helped the Imam with administrative tasks on the landings and they often discussed religious issues. The man also took educational courses; indeed, he had taken Key Stage 2 Maths and English exams the week before he died and had planned to take advantage of further educational opportunities in prison. After his death his family found out that he had been awarded an "A".
13. On 28 February 2007, the man moved to cell D1-33 on the Vulnerable Prisoners' Unit. The reason for his transfer is not recorded on any of the documents provided by the prison. The unit accommodates men who feel that, for a variety of reasons, they would not be safe on a normal wing. The man's probation officer told my investigator that the man had mentioned to her that he was having problems on A wing. One of the man's cellmates told my investigator that he thought the man moved to the Vulnerable Prisoners' Unit because he was having trouble related to events that had happened before he came into Pentonville.
14. The man settled into life on the landing. Staff and prisoners who spoke to my investigator described him as a mature young man who was polite and dignified. He was very quiet and reserved but made one or two friends with

15. On 12 March 2007, the man was convicted of a number of serious offences at Snaresbrook Crown Court. The court asked for a pre-sentence report and a psychiatric report to be prepared. On 22 March and 12 April a consultant forensic psychiatrist assessed the man. He concluded that he had a mild depressive disorder as a result of being in prison, and arranged a follow-up appointment for 10 May.
16. On 18 April, the man received word that his partner had miscarried a baby. He told an officer on the wing who referred him to the Imam. The Imam spent some time talking to the man. He also arranged for the man to use an office telephone to speak to his partner. According to his fellow prisoner, the man was "devastated" by the news and felt very frustrated at being apart from his partner at such a sad and difficult time. He withdrew into himself even further.
17. Five days later, the man was sentenced to four terms of life imprisonment and ordered to serve a minimum of ten years before being considered for release on licence. The man's cellmate told my investigator that he and the man had discussed possible sentences before the court appearance. According to the man, the judge was known as "harsh" and he knew it might be a stiff sentence.
18. When the man returned to prison after sentencing, he went through the normal reception process. The prison doctor examined the man in reception at 7.30pm. The man told the doctor that he felt tired and "low" but made good eye contact and denied having any thoughts of suicide. The prison doctor assessed the man as being at moderate risk of self-harm and opened an ACCT plan. (An ACCT document describes the problems facing a prisoner at risk of harming himself and implements a plan to give support through a period of crisis.) The prison doctor also referred the man to the mental health team. He asked for him to be assessed within a week but this did not happen. The prison doctor also prescribed sleeping pills for three days.
19. Staff discussed admitting the man to the healthcare centre but decided to keep him on D1 and provide support there. The ACCT case manager instructed staff to check on the man each hour, day and night. A fellow prisoner, a man whom the man had known in the community, was moved into the man's cell and the two men spent all night talking. The man's new cell mate was a Listener but he told my investigator that he and the man always spoke as friends - he did not act as a Listener for the man. The man told his cellmate that he did not think he needed to be on an ACCT and that the staff were making an unnecessary fuss. He also said that he was probably going to appeal against his sentence. However, for most of the night the two men chatted about the past rather than the present or future.
20. The following morning (April 24), an officer carried out an ACCT assessment interview with the man. The ACCT assessor told my interviewer that he

21. The man was not willing to talk about his feelings or problems and gave fairly brief answers to questions. The ACCT assessor asked him several times if he wanted to die, to which he replied that he did not. The man said that he was in regular contact with his family by telephone and letter. He told the ACCT assessor that there was nothing the officers could do for him and that, although he knew Listeners and the Samaritans' telephone were available, he was "not interested". The ACCT assessor was concerned at how withdrawn the man was, so he passed on his concerns to the senior officer on duty on D1 as soon as he left the man's cell. I should add that it would have been helpful if the ACCT assessor had also made an entry in the ongoing record section of the ACCT plan for staff on later shifts to read.
22. The man slept for most of the remainder of the day. By 4.30pm he was up and he helped serve the evening meal. An officer noted that, although he was less talkative than normal, he did chat as he was working. The officer also wrote that the man seemed a lot better than he had been during the earlier part of the day. That night, he watched television until after 4.00am. However, he got up the next morning in time to take part in association at 9.30am.
23. At 10.30am on April 25, the Imam visited the man in his cell and they spoke for approximately two hours. The Imam told my investigator that around the time the man was convicted he had stopped attending the mosque. On this occasion they talked about the sentence and how to cope with it. The Imam said that the man was very quiet and calm. He was worried that the man might harm himself but the man said, "Of course not. Of course not. Of course not." The Imam continued to talk to the man when he saw him on the landing and always invited him to attend the mosque again or to visit privately. The man always politely refused.
24. Once an ACCT plan is opened a case review should be held within 24 hours. The man's review took place almost two days later and appears to have taken 10 minutes. The meeting was chaired by a senior officer, with the man and a prison officer also present. The man told the officers that he was fine and had no urge to harm himself. He said that he was in regular contact with his family and they were giving him a lot of support. He had also spoken to the Imam. He said that he understood why staff had opened the ACCT plan, but that everybody was fussing over him and asking if he was okay. The prison officer said that the man was by nature a quiet person and kept himself to himself. Those present all agreed that the ACCT plan should be closed. A post-closure review was not held.
25. On 6 May, an officer from the wing had a long chat with the man about his relationship with his partner and the impact of his lengthy sentence on her. The man was assessed by the consultant forensic psychiatrist on 16 May for

26. The next entry in the man's record was made on 25 May. An officer noted that the man was mixing well with the other men on the wing. According to the man's cell mate, about this time the man helped staff cut down a prisoner who had tried to hang himself on the landing. The man's cell mate reported that this had affected the man, who talked about what he had seen. When my investigator asked for details of this attempted hanging, staff reported that a prison officer had discovered a prisoner hanging on 23 May. The officer said that he and his colleagues had dealt with the situation and the man had not been involved. From the man's cell mate's recollection of his conversation with the man, it would seem likely that, even if he had not been involved, he had observed what had happened.
27. On 9 June, staff found a mobile telephone in the cell that the man and the other prisoner shared. Both men were put on disciplinary report. When staff examined the phone they found a text message from a woman in which she had ended her relationship with an unnamed man. The man's cell mate told my investigator that the man had nothing to do with the phone and the text message on it had not been for him. The disciplinary charge against the man was subsequently dropped.
28. On the morning of 18 June, the man's cell mate went to court for the first day of his trial. At lunchtime the man did not collect his meal, so an officer went to his cell and asked him if he was alright. The man replied that everything was fine and it was just that he was not hungry. The man's cell mate told my investigator that the man sometimes missed meals. When the man collected his food at teatime, the officer who had spoken to him earlier asked him if he was hungry after missing lunch and he said that he was.
29. The man then went to a second prisoner's cell and asked to borrow some coffee. The second prisoner told my investigator that at the time the man was wearing traditional clothes, which he did when going to the mosque and sometimes when "he was feeling religious". They talked briefly and laughed until the prison officer called on the man to return to his cell. The second prisoner said that the man seemed happy, not upset about anything. As the man went into his cell he gave the prison officer a wry smile at being the last person to go into their cell. The prison officer said that he would see the man in the morning to which the man replied, "Fine."
30. Under normal circumstances, a prisoner who is on trial will return to prison and his own cell each evening. However, the man's cell mate's trial did not begin on 18 June as expected and Pentonville was subject to a 'lock-down' which meant that they could not accept any prisoners from court. The prisoner's cell mate therefore spent the night in a cell at the court. This left the man alone in his cell.

Tuesday 19 June

31. During the night of 18/19 June, an Officer Support Grade (OSG) and a prison officer on D wing were on duty. D wing is a large unit with five landings holding almost 400 prisoners. For the evening and morning roll checks, the OSG and D wing officer agreed which landings each of them would check. The OSG was responsible for counting the men on D1, so he made a list of each cell and the number of men occupying it. The officers did the evening check shortly after they came on duty at 8.45pm. During the night they patrolled the landings, answered cell bells and checked on the men on open ACCT plans.
32. At approximately 5.30am on 19 June, The OSG began his morning roll check on D1. He worked his way along the left hand side of the landing and then crossed to the right side. When he checked D1-33 he could not see anyone in the cell although his list showed there should be a prisoner inside. The OSG shouted to try to get the occupant to show himself but nothing happened. He explained to my investigator that sometimes prisoners cannot be seen as they hide during roll counts as a game, or they might be slouched on the toilet.
33. The OSG raised the alarm and colleagues came to assist him. There are slight variations in their descriptions of who carried out which actions. (I believe that the differences are the result of all the focus being on trying to save the man rather than on which colleague was assisting at any given moment.) From the accounts provided by staff, I have concluded that what happened was as follows.
34. The OSG could hear the D wing officer and the night orderly officer, in the office at the top of the stairs to D1. He went to them and said that he could not see the prisoner in cell D1-33. They went to the cell to check, whilst the OSG went to the wing office to check the name of the man in the cell.
35. The night orderly officer looked through the observation hatch and could not see anyone, so he called for assistance over the radio. The assistant night orderly officer responded to the call. The night orderly officer opened the cell door and went in with the D wing officer, the assistant night orderly officer following closely behind. The night orderly officer saw that the bed was empty and the two lockers which should have been against the right hand wall were almost in the middle of the room. He could not see the wall at the back of the cell. As he moved into the cell and past the furniture, he saw the man sitting on the floor with a strip of bed sheet round his neck and attached to the window bars. He immediately radioed for Level 1 (serious emergency) medical assistance (this call was timed at 5.40am). The night orderly officer and assistant night orderly officer lifted the man up and used D wing officer's anti-ligature knife to cut the sheet and remove it from the man's neck. The officers laid the man on the floor and the D wing officer moved the furniture out of the way to make more room in the cell. The assistant night orderly officer felt for a pulse but did not find one.
36. When the night duty nurse who is responsible for responding to emergencies heard the call for Level 1 assistance, she collected the bag with resuscitation

37. When the night duty nurse arrived at the cell, she felt for a pulse but could not find one. She asked the night orderly officer to call an ambulance. She noted that the man was very cold, stiff and clammy, and so began CPR with the assistant night orderly officer assisting her. With some difficulty (because the man's jaw was clenched) she put an airway into his throat to help get oxygen into his lungs. Then she administered oxygen and the assistant night orderly officer carried out chest compressions. When the man did not respond to the CPR, the night duty nurse attached the defibrillator. The machine carried out its checks and instructed the staff not to shock the man. As it did so, three paramedics arrived and took over the man's treatment. They continued the resuscitation attempt from 5.56am until 6.23am when they decided that nothing further could be done.
38. The duty care team member was available for the staff who had found and attempted to resuscitate the man. At 7.15am, the Governor chaired a hot debrief meeting, and half an hour later he held a full staff meeting. All open ACCT plans were reviewed by an assessor. The Listeners were briefed and support put in place for them. The senior officer in reception assessed the ACCTs of prisoners who were going to court that morning and, where the prisoner had already left the prison, he informed court staff that the ACCT must be reviewed. At 8.56am, the senior prison doctor, confirmed the death. When the man's cell mate returned from court later that day, a governor met him in reception. He took the man's cell mate into a private room where he broke the news of the man's death and offered him support.
39. When the man had first arrived at Pentonville, he had nominated his sister as his next-of-kin. The Safer Custody manager, the prison family Liaison Officer, and a principal officer visited the man's sister home to break the news. Before they left, the prison family liaison officer gave the family a booklet produced by the prison containing useful information that had his contact details on the front cover. The governing governor later spoke to the family by telephone and gave them his mobile phone number.
40. The following day, the prison family liaison officer visited again along with the Imam. The Imam offered to help in any way he could and the family asked him to arrange a Muslim funeral. The prison family liaison officer also visited the man's partner and provided information and support to her.
41. The funeral was held on Saturday 23 June and was attended by two prison family liaison officers. The prison contributed financially to the funeral and helped with transport throughout the week as arrangements were made.
42. On 27 August, a rock concert was held in Pentonville's chapel to raise awareness of the issue of suicide among young men. The role of Listeners in

ISSUES

The man's reflections on his crime and the consequences of his sentence

43. After his arrest, the man admitted his guilt almost immediately and pleaded guilty to the majority of charges against him. He could offer no explanation for his actions, and over several months he told a number of people that he could not understand his behaviour. He was aware of the seriousness of the offences and did not seek to minimise his guilt. He told his probation officer that he was ashamed of and sorry for what he had done.
44. The man said to the psychiatrist who assessed him, "I deserve to go to jail. I deserve a lot worse than jail." He told his probation officer, "I'd have been executed under Islamic law." He told both his probation officer and the psychiatrist that he wanted to understand his behaviour and was eager to have counselling and do courses to get to the root of his actions. The man's probation officer discussed various options with him, including one long and particularly demanding intervention. The man was open to doing even the most demanding offending behaviour courses.
45. The man's probation officer told my investigator that the man was aware of how his offences conflicted with his faith. When the probation officer met the man to prepare the pre-sentence report, he told her that he had lost his faith. (He had never said this to the Imam.) The Imam told my investigator that the man had borrowed a book on Islamic law from him. He regarded this as a very unusual request as Islamic law is usually studied only by scholars. However, the man had clearly read the book, judging from how well thumbed it was when it was returned to the Imam after the man's death. Among the papers found in the man's cell afterwards was an envelope. On it a single word had been written over and over again - "repentance".
46. After the man was sentenced, he appeared to be coping. The man's cell mate said that the man appeared "laid back" about his sentence. However, on one occasion when he commented on how well he was taking it, the man replied, "Yes. You would think," rather than saying, "Yes. I suppose," as he had done before. In retrospect, the man's cell mate felt that perhaps the man was not as comfortable with the sentence as he had appeared.
47. On 6 May 2007, an officer on the wing had a long chat with the man about his relationship with his partner and the impact of his lengthy sentence on her. The officer told my investigator that the man was considering how hard it would be for his partner to cope with him being in prison for such a long time. Another prisoner on D1 landing, told my interviewer that the man had remarked that by the time he was released his one-year old son would be a grown man.

Access to Listeners

48. When the man arrived at Pentonville he was told that Listeners were available, as was the telephone to talk to the Samaritans. After he was

The man's move to the Vulnerable Prisoners' Unit (VPU)

49. The man moved from A wing to the Vulnerable Prisoners' Unit on D wing on 28 February 2007. Information from the man's probation officer and cellmate suggest that the man was being 'hassled' in relation to events that had occurred outside of prison. However, there is no documentation in the man's records to confirm or exclude this. There is no written request from the man asking to move for his own safety nor is there an entry in his wing history sheet to explain why he moved. The lack of information is unhelpful. It should not happen that a prisoner is located in a unit for vulnerable prisoners without his records containing a written explanation for the move.

The Governor should remind staff that, when a prisoner is moved to the VPU, the reason is entered in his records.

50. The man found it difficult living in the VPU. He told his probation officer that he did not want to be there as it meant getting 'flak' from other prisoners. Once a prisoner has been in a VPU, it can be very difficult to return to a cell on the main wings. Prisoners on normal location may stigmatise those in the VPU and this attitude can make it hard to move a prisoner out of the unit. According to the second prisoner, the man never went out during exercise periods although he did go to the gym. When my investigator visited D1 landing she was shown the exercise yard used by the men on the unit. It is overlooked by two accommodation blocks housing prisoners on normal location.

The man's desire to work

51. During his time on D1 landing, the man asked on a number of occasions to be assigned work. The officer on the wing offered him work making up tea packs (for the prisoners to use in their cells in the morning), but the man said that he wanted something more interesting. The officer sometimes asked the man to help out on the hotplate, serving food to the other prisoners when he did not have enough workers. However, he could not make the position permanent until the security department had cleared the man for work. My investigator could find no evidence that staff had requested clearance for the man, and staff could not explain why it had not been done.

The Governor should review the procedures for clearing prisoners for work to ensure that applications are recorded and processed in a timely manner.

ACCT

52. When the man returned to Pentonville after being sentenced to life imprisonment, the prison doctor assessed his risk of self-harm as medium. He opened an ACCT plan and, as noted earlier, a fellow prisoner who was also the man's friend was moved into the man's cell. The following morning the ACCT assessor spoke to the man and was so concerned about him that he spoke to the senior officer on duty. However, there is no sign of these concerns being documented in either the ACCT plan or the wing observation book. It appears, therefore, that the information was not readily available to the staff in the case review meeting who decided to close the ACCT the following day.

53. PSO 2700 'Suicide Prevention and Self-Harm Management' stipulates that after an ACCT plan is closed, a post closure interview must be held within seven days. This did not happen in the man's case. The senior officer who chaired the review that closed the ACCT plan, told my investigator that she was not aware of this requirement. The procedure on D wing is for staff to 'keep an eye on' a prisoner after he comes off an ACCT plan and, if necessary, make an entry in his history sheet.

The Governor should ensure that all prisoners on ACCT plans have at least one post closure interview, as required by PSO 2700.

54. My investigator judged that the entries made in the ACCT recording staff interaction with the man were of good quality, as were the management checks. The policy at Pentonville is that, in addition to a management check during the day, all ACCTs are also checked each night by the night orderly officer or his assistant. They assess whether each document has been fully completed and note any omissions or problems. They write a report on their findings which is then passed to a governor for action. This is good practice.

Health

55. A clinical review was carried out investigating the clinical care that the man received during his time in Pentonville. She concludes that his care was appropriate and timely. However, she also identifies a number of procedures that could be changed to optimise the delivery of care:

The Head of Healthcare should set up a recall system for patients who miss the second part of their reception health screening assessment.

The Head of Healthcare should set up systems to ensure a referral to the mental health team is acted upon.

The Head of Healthcare should review nurse staffing levels in the main prison at night with a view to improving staff working conditions and reducing professional isolation and improving patient safety.

The Governor and Head of Healthcare should set up procedures to enable staff from the healthcare centre to assist the staff in the main prison during an emergency situation at night.

Nationally a protocol should be developed whereby healthcare staff should have ready access to patients' medical records held in other prisons.

Family liaison

57. After the man's death, the deputy head of prisoner care, the prison family liaison officer and principal officer visited the family to give them the news. They answered the family's questions and explained the support that was available. Before they left, they gave the family a booklet that clearly explained what would happen and giving contact details of organisations that provide support for bereaved families. On the front cover of the booklet are contact details for the prison family liaison officer and another member of staff for occasions when the family liaison officer is not available. As noted above, the governing governor also gave the family his mobile phone number. I commend the use of the family liaison booklet as good practice as it gives the family a great deal of helpful information in a very accessible way.
58. The following day (20 June), the prison family liaison officer returned with the Imam to discuss the funeral. The family asked the Imam to arrange and officiate at a Muslim funeral for the man. He did so and was sensitive to the fact that the family do not follow Islam. He arranged for the women to be present at the graveside, which is not usual at Muslim funerals. The Imam's actions, and those of the Governor and family liaison officer, were examples of good practice and should be commended.

RECOMMENDATIONS

The Governor should remind staff that, when a prisoner is moved to the VPU, the reason is entered in his records.

The Governor should review the procedures for clearing prisoners for work to ensure that applications are recorded and processed in a timely manner.

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Good practice

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