

**Investigation into the circumstances surrounding the
death of a man at HMP Edmunds Hill
in August 2008**

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

April 2009

This is the report of an investigation into the apparently self-inflicted death of a man at HMP Edmunds Hill in August 2008. The man was found hanging in his cell at 7.30am during a routine check. He was pronounced dead by paramedics at 8.06am. The man was 27 years old.

I offer my sincere sympathies to his family for their loss.

I appointed an investigator from my team to investigate the circumstances surrounding his death on my behalf. She was assisted by another of my investigators. I would like to thank the Governor and his staff for their support during the investigation. My lead investigator also received excellent assistance from the appointed liaison officer at Edmunds Hill. I am also grateful to the clinical reviewer who was appointed by Suffolk Primary Care Trust to conduct a clinical review of the care provided to the man.

The man had been recalled to prison two months before his death, having breached the conditions of his licence. In my experience, recalled prisoners often feel confused by the reasons for their return to prison, and may be uncertain about when they will again be released. I also sense that the prisons that receive them are not always sufficiently prepared for the task. However, I do not believe that his recall to prison was a critical factor in his death. Concerns about his relationship with his wife and access to his son appear to have been pivotal.

The man did not often share his thoughts or worries with friends or staff at Edmunds Hill. He had some history of depression and other mental health problems, but gave staff at the prison no indication that he was struggling to cope. However, my investigation has revealed a failure to pass on and record some information relevant to risk on the night before his death.

The death of the man was the first to have occurred at Edmunds Hill since I took over responsibility for investigating all deaths in prison custody in 2004, and the first since the prison became a male establishment. Clearly, the prison has little experience of deaths in custody and most of my recommendations focus on the gaps in their procedures after his death. I have made six recommendations and note one area of good practice.

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

Stephen Shaw CBE
Prisons and Probation Ombudsman

April 2009

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SUMMARY

The man who is the subject of this report was initially sentenced to 16 months imprisonment for driving offences in March 2007. He was released on licence in September of that year. He breached the conditions of his licence and was recalled to prison on 4 July 2008. Having been arrested by the police, the man was taken to HMP Pentonville. He was transferred to HMP Edmunds Hill on 18 July and had been there almost six weeks when he died. The man had been in prison several times before.

The man had a history of depression and paranoia, and had been diagnosed with a personality disorder with explosive outbursts. He had received treatment in the community, but had not complained of any symptoms for a couple of years.

Healthcare staff at Edmunds Hill were aware of the man's previous mental health problems but, during assessments, found that he was no longer suffering from them. He denied feeling depressed and said that he had no thoughts of harming himself or committing suicide. He appeared to be positive and motivated and was in the process of appealing against his recall to prison. Staff on the unit where he lived described him as someone who was "getting on with his sentence". He gave them no cause to worry and seemed to have adjusted well to life at the prison.

The man's friends on his unit said that he was sometimes worried about his relationship with his wife and losing contact with his young child. About two weeks before he died he told one friend that he felt like killing himself. His friend did not tell anyone else about their conversation, but spent time trying to reassure and comfort him.

On 27 August 2008 the man repeatedly tried to telephone his wife and finally spoke to her at about 6.30pm. During the telephone call, he was upset and anxious. When the call finished, his friends became worried about him because his mood seemed low and he was not himself.

Prisoners were locked in their cells at 6.45pm. A fellow prisoner was concerned about the man's welfare and asked a member of staff on the unit to keep an eye on him. Staff discussed the matter and checked his file for any reports that he was at risk of harming himself. They found no such indication and decided that staff should check on his welfare the next day. Staff coming on duty that evening were not told about the prisoner's concerns. No entry was made in the staff observation book or in the man's prison file. Staff were not required to make any checks on him overnight.

At 7.30am on 28 August, staff carrying out a routine check on the unit discovered the man hanging from the window of his cell. They quickly went inside and cut the ligature. Healthcare staff arrived very soon afterwards, but it was clear that he had been dead for some time and that nothing could be done to help him. The paramedics pronounced him dead at 8.06am.

THE INVESTIGATION PROCESS

1. My office was notified of the man's death on 28 August 2008 and the investigation was allocated to one of my investigators later that day. My investigator and her colleague visited HMP Edmunds Hill to open their inquiries on 1 September.
2. My investigator issued notices inviting staff and prisoners to contact her with any information they felt might be relevant to the investigation. Three prisoners wrote to my office about the man's death. They were all interviewed as part of the investigation. My investigator and another colleague carried out interviews with staff and other prisoners at the prison during October 2008.
3. Suffolk Primary Care Trust (PCT) appointed a clinical reviewer to undertake a clinical review. My investigator and the clinical reviewer conducted several joint interviews with members of the prison's healthcare department. I am also grateful for the co-operation of Suffolk Constabulary who shared information with my investigator.
4. My investigator was provided with relevant documentation covering the man's time in prison, including a copy of his core prison record, his Inmate Medical Record (IMR), and the staff incident reports written after his death. She was also able to listen to a recording of his final telephone conversation on 27 August. There is no Closed Circuit Television (CCTV) in place on unit 5/6 at Edmunds Hill.
5. During the investigation my investigator met the chair of the prison's Independent Monitoring Board and a representative of the local branch of the Prison Officers' Association. She also spoke to the man's probation officer and criminal defence solicitor.
6. One of my family liaison officers contacted the man's family to invite them to be involved in the investigation process. The family liaison officer spoke to the man's mother and wife who felt that he had showed no signs of being suicidal. They had a number of concerns about his death. In particular, these were as follows:
 - Whether Edmunds Hill had been aware of the man's history of depression, and, if so, what they had done about this.
 - If staff on his unit had known that he was vulnerable on 27 August, as suggested in a letter sent to his mother by another prisoner. My investigator subsequently identified that this letter had been written by the prisoner who had raised concerns on 27 August and who was interviewed during the investigation.
 - Whether prisoners were checked on overnight.
 - Why the man had not been found until 7.30am.
 - Why two inhalers had been found in his cell.
 - If the man was receiving any healthcare treatment, and whether he had any health problems that meant he should have been checked on during the night.
 - If the man had a cell bell which he could use to call staff during the night.

- If the man's unit was covered by CCTV.

In conversation with the family liaison officer, it became clear that the family had not been offered funeral expenses by the prison as required by the relevant Prison Service Order. My investigator agreed to look into this matter, and also consider the level of liaison and support the family had received from the prison following the man's death.

I hope that this report answers all the family's questions.

HMP EDMUNDS HILL

7. HMP Edmunds Hill is a category C training prison near Bury St Edmunds, Suffolk, holding up to 366 prisoners. It became an adult male prison in 2005, having previously been a female establishment. It accommodates sentenced prisoners serving less than three years or having less than nine months of their sentence left to serve. Accommodation in the prison is arranged across eight units and prisoners may be placed in single or double cells.
8. Her Majesty's Chief Inspector of Prisons, made a full announced inspection of the prison in October 2006. At that time, the Chief Inspector noted that the prison had come a long way since its role change but that there were a number of shortcomings to be addressed. She found that whilst the prison was generally "calm, controlled and safe", suicide and self harm procedures were "weak". Relationships between staff and prisoners were commended, and staff were found to interact with prisoners in a thoughtful and caring way. However, Dame Anne reported that the prison's personal officer scheme needed some improvement.
9. Each penal establishment in England and Wales is monitored by an Independent Monitoring Board (IMB). The Board consists of members of the local community who have full access to every prisoner and each part of the prison. The IMB produces an annual report, with the last available report for Edmunds Hill covering the period January to December 2007. The IMB reported that, in general, the prison was well managed and run. However, they agreed with the Chief Inspector that the personal officer scheme was still underdeveloped.

Recalled prisoners

10. In 2005, the Chief Inspector conducted a short review of recalled adult male prisoners because of the growing numbers being recalled to prison after breaching the conditions of their licence. The review concluded that neither recalled prisoners, nor the prisons that received them, were adequately prepared. Recalled prisoners often did not have enough information or understanding of their situation, and receiving prisons were not always given enough warning of recalled prisoners' arrival. Few prisons were found to have appropriately trained staff in place to help recalled prisoners understand the process.
11. The Chief Inspector found that recalled prisoners sometimes remained outside normal prison routines, either because they chose to or because staff were not sure of their status. This meant that:

"... risks and needs were not picked up in the way that should happen with newly-received prisoners. Vulnerabilities, for example, to suicide and self-harm ... could go unnoticed and prisoner frustration and anger at their situation might not be promptly identified and managed."
12. The review concluded that prisons should provide the following to recalled prisoners:

- “Safe reception and induction and effective safer custody support
- Effective legal advice
- Proper access to regimes
- Preparation for re-release ...“

Privacy keys

13. All prisoners with single cells at Edmunds Hill have privacy keys for their cells. The keys can be used during periods of the day when the cells have been unlocked by staff. Each prisoner’s privacy key is individual and only allows them to lock and unlock the door to their own cell. The privacy locks mean that prisoners cannot enter other cells during periods of unlock, although keys held by staff override the privacy locks and allow access to cells at all times. At night, when prisoners are locked in their cells, only keys held by staff will unlock the cell doors.

Cell bells

14. Each cell at Edmunds Hill is fitted with a cell bell. On the man’s unit, the cell bell is located on the wall by the cell door. The cell bell enables prisoners to summon staff assistance when they are locked in their cells, or when the prison is in patrol state. (Patrol state is when staffing is at a minimum and prisoners are locked in their cells, for example, overnight.) On pressing the cell bell, an alarm panel in the unit office lights up, showing staff exactly which cell requires assistance. The cell bell can only be switched off by staff pressing the reset button on the wall immediately outside the cell in question. Cell bells are only intended for emergency use.

Radio call signs

15. Staff at Edmunds Hill use specific call signs when alerting healthcare staff to incidents in the prison. ‘Code Blue’ is used to indicate a medical emergency where someone is not breathing or is having difficulty breathing. ‘Code Red’ is used to indicate a medical emergency where someone is bleeding. The use of such a code system informs healthcare staff which medical supplies and equipment may be needed.

KEY EVENTS

16. The man appeared at Harrow Crown Court in March 2007. He was sentenced to 16 months in custody for dangerous driving and served his sentence at HMP Wormwood Scrubs. His prison records from Wormwood Scrubs indicate that it was an uneventful period. There are no documented concerns about the man's mental health or vulnerability.
17. In September 2007 he was released on licence until May 2008 when his sentence would expire. One of the conditions of his licence was that he had to live at an address specified by probation. He was found a place in approved premises (hostel accommodation provided and managed by the Probation Service) in North London. However, in November 2007 the man left the approved premises. He told probation staff that he did so after a fight with another resident. The police were notified that he had breached his licence and should be returned to prison to serve the remainder of his sentence.
18. The man, his wife and baby, travelled to Ireland for several months. He was considered to be unlawfully at large. He was finally arrested by the police and taken to HMP Pentonville on 4 July 2008. On arrival, he underwent a first reception healthscreen with a nurse. (The purpose of the healthscreen is to identify any immediate physical or mental health concerns and whether any referrals need to be made to the doctor or other specialist service. At Pentonville, the healthscreen is recorded on a computer and a printout is made for the prisoner's file.) The man's healthscreen recorded that he suffered from asthma but otherwise was physically healthy. The doctor prescribed two inhalers for his asthma. The nurse recorded that he was of "normal mental state" with no current thoughts of suicide or self harm. She noted that he had previously suffered with an "unspecified depressive disorder".
19. In reception at Pentonville the man also underwent a Cell Sharing Risk Assessment (CSRA). This is to assess the level of risk a prisoner poses to other prisoners and, therefore, whether he is suitable to share a cell. The first part of the CSRA is completed by a member of prison staff and the second by a member of healthcare staff. The CSRA also provides staff with another opportunity to assess whether the prisoner has a history, or any current risk, of self harm or suicidal thoughts. The man was assessed as being of low risk to others, with no concerns noted.
20. During his short time at Pentonville he gave staff no cause for concern. On 18 July, he was transferred from Pentonville to Edmunds Hill to serve the remainder of his sentence. His Prisoner Escort Record (PER) noted that he could be violent and might be an escape risk. (The PER provides information about the risks posed by a prisoner being transferred either from police custody, court, or between prisons. It is based on known information such as the prisoner's offences or medical history and their risk of escape or self harm or suicide.) There was no indication that the man was likely to harm himself or attempt suicide.

21. Whilst in reception at Edmunds Hill the man underwent another CSRA. Once again, no risks or concerns were identified and he was assessed as low risk. He was placed in a double cell whilst he went through the prison's induction process. During his induction interview on 21 July he was asked if he had ever harmed himself or if he had attempted suicide in the last two years – he said he had not. He also denied having used drugs or alcohol in the past.
22. A nurse carried out the man's first reception healthscreen on 18 July. In interview, she said she had read the healthscreen carried out at Pentonville. The nurse recorded that, when asked, the man reported no history of depression, self harm or drug use. However, she noted that he said he had had contact with mental health services at his local hospital two years previously because he had suffered with paranoia. The nurse told my investigator that, because of his previous contact with mental health services, she referred him to the mental health in-reach team for assessment as a matter of course. She also recorded that he suffered with asthma and had a heart murmur. She knew that he had been given two inhalers for his asthma at Pentonville and that he still had them with him on arrival at Edmunds Hill.
23. On 24 July, the man was discussed at a multi-disciplinary team meeting, attended by staff from the prison mental health in-reach team. His history of depression was noted but it was concluded that he was not currently showing any signs of mental ill health. Nonetheless, it was decided that he should be seen by the doctor for a review.
24. The man's mother, wife and son visited him on 27 July. Two days later he was visited by his criminal defence solicitor. In interview, his solicitor said the man was upbeat and positive. She said that at no time did he mention feeling depressed. She explained that he had fully understood the reasons for his recall to prison and, whilst keen to appeal against the decision (the appeal to the Parole Board was ongoing at the time of his death), he appeared to be coping well.
25. The solicitor told my investigator that the man had made it clear to her and to prison staff that he wanted a single cell. His solicitors wrote to the prison on 30 July to ask that his applications for a single cell be dealt with as a matter of urgency due to his history of mental health problems and previous attempts to harm himself. In the letter, the solicitors also mentioned that the man had asked to see someone from the mental health team but had not yet been seen. The residential manager at Edmunds Hill replied on 1 August. He explained that the man had completed the induction process and had, that day, been allocated a single cell on unit 5/6. The residential manager also explained that, after assessment by healthcare staff, no current mental health problems had been identified but that the man had been referred to the doctor.
26. Following the multi-disciplinary team meeting on 24 July, the man was seen by a prison doctor on 6 August. The doctor noted in the man's records that he had a history of depression and had been diagnosed with a "personality disorder (explosive type)". The doctor recorded, however, that the man had not received any treatment for these conditions for over a year. The man told the doctor that he had misused alcohol in the past but did not do so any longer. He also said he

had never misused drugs. He denied having any thoughts of harming himself or suffering from anxiety or aggression. The doctor concluded that he should be referred back to the mental health team for assessment because of his personality disorder.

27. A mental health nurse met the man on 8 August and completed a primary mental health screen. There appears to be some confusion amongst healthcare staff about whether the man had referred himself, been referred by the nurse at his initial healthscreen, or by the doctor on 6 August, or a combination of the three. Certainly the man's records indicate that he had requested a referral to the mental health team.
28. During the primary mental health screen (which is designed to gather some basic information about the mental health of the patient and identify if they need further intervention from the mental health in-reach team), the man denied any thoughts of self harm or that he was low in mood. He told the mental health nurse that he had been seen by the psychiatric team at his local hospital and had been diagnosed with a personality disorder. He told her that he had used cannabis as a teenager but did not admit to any other drug use. Under the section 'Past deliberate self harm and suicide attempts' the mental health nurse wrote, "Yes he has, but he didn't tell me this." In interview, she explained that, whilst the man had not admitted to this, she had read his file later which mentioned that he had harmed himself in the past.
29. The mental health nurse said that the man had seemed positive and told her that things were going well in his life. He said he had a good relationship with his wife and that they had a young child. She felt he was well motivated to "get his life on track". The nurse asked him to rate his mood on a scale of one to ten, with ten being good. He said his mood was currently at eight.
30. The man was asked why he wanted to see the mental health team and he replied that he wanted help to challenge his licence recall. The mental health nurse explained that it was quite common for prisoners to think that they could challenge their recall for health reasons, and that she could assist them with this. She told him that she could not help him with his recall and he became angry with her, which she saw as a sign of his motivation.
31. After meeting him the mental health nurse was satisfied that, despite his history, he currently showed no signs of depression and had no thoughts of harming himself. She knew he had been seen by the doctor who could have prescribed anti-depressants for him if that had been necessary. The mental health nurse explained that she too could have prescribed anti-depressants, had she thought it necessary, but she was satisfied that he did not currently need them. She decided that he did not need any further mental health intervention at that time, but told him how he could access help if he needed it at any point in the future.
32. Two days later, on 10 August the man was visited again by his mother, wife and child. They did not mention to staff that they had any specific concerns about him following the visit.

33. The man's time at Edmunds Hill was uneventful. Staff interviewed as part of this investigation said that they did not know him well but that he was no trouble on the unit. The staff observation book for unit 5/6 and the man's personal prison file show that staff thought him to be settling in well to life at Edmunds Hill, giving them no cause to worry. He was keen to work whilst in prison and staff on his unit were helping to arrange this. In the meantime, he was attending education every day.
34. Two officers were allocated as the man's personal officers. Members of staff at Edmunds Hill may be personal officers for up to 20 prisoners on their unit. In interview one of the personal officers explained that a personal officer is expected to be the prisoner's "first port of call" if they have a problem or question. Personal officers also meet their prisoners once a week and must make entries in the prisoner's file so that other staff are kept informed of any concerns. Weekly entries were made in the man's prison file by both officers.
35. The officer said that he had not got to know the man very well during his time at Edmunds Hill because he was a quiet man who seemed to take being in prison "in his stride". He was aware that the man had a few friends on the unit, some of whom he had known from previous sentences or from the community.
36. As part of the investigation the investigator and a colleague interviewed a friend and fellow prisoner of the man, at HMP Blundeston. Before his transfer to Blundeston the friend had a cell on the same corridor as the man on unit 5/6 at Edmunds Hill. They also had mutual friends on the outside. The friend said that he and the man often spent their association time together. (Association is the period when prisoners are free to mix with each other, make telephone calls, and spend some time outside. At Edmunds Hill, association takes place between 4.45pm and 6.45pm on weekdays.) He remembered that, about two weeks before he died, he had talked to the man about his relationship with his wife. The man explained that he was feeling "stressed" about the relationship and was worried that his wife was planning to return to Ireland with their child. The friend told my investigators that, during this conversation, the man said that he felt like killing himself. The friend said that he told him not to be silly and to keep focused and think of his child.
37. My investigators asked the friend if he had told anyone else about this conversation and, in particular, about the man mentioning killing himself. He explained that he had not because he had spent time reassuring the man and "talking that silliness out of him". My investigators asked the friend if he had taken the man's words seriously. He described the man as "very stressed" but said that he thought he was "a strong minded bloke".
38. A second prisoner who was also a friend of the man told my investigators that the man had talked to him about his relationship with his wife, and his fears that he would lose contact with his son. This prisoner said that the man had never mentioned feeling suicidal.
39. While in prison, prisoners are given an individual Pin number to make telephone calls. This allows the prison to record and monitor calls being made by each

prisoner, if necessary. The records relating to the man's Pin number show that on 27 August, during association he telephoned his wife 19 times and his mother four times. The second prisoner said that the man had become agitated and anxious when he tried several times to call his wife and there was no answer. His records indicate that on 17 occasions when the man tried to speak to his wife that afternoon there was no reply. At 6.26pm he spoke to his wife. My investigator has listened to a recording of that conversation, and it appears that he found it difficult and became very anxious. The call lasted for about five minutes and ended when his wife put down the phone.

40. The friend remembered speaking to the man in the exercise area shortly after that telephone call. He said that the man was clearly upset by the call and was particularly worried about his relationship with his son. In interview, the friend said:

“... [the man] has explained to me that ... if he can't be with her and have his child, there was never going to be an in between, he was never going to be a part time dad, he was never going to have someone else there [looking after his child].”

41. Shortly after the man made this telephone call, prisoners on units 5/6 were told to return to their cells for the night. A third prisoner and friend of the man who had a cell directly opposite him, was also interviewed by my investigators. He said that each night before they were locked in their cell he would always check that the man and other prisoners with cells nearby had everything they needed for the night. As usual, he asked the man if he wanted any tobacco or anything else. He replied “... I don't need nothing because I can't take nothing down tonight ... me and my wife are finished.” The third prisoner said he asked again if there was anything the man wanted, to which he replied, “No I can't take nothing tonight, it is time for me to go home.” The prisoner was very worried by his reply but he did not speak to any member of staff about his concerns. He knew, however, that the man's friend was also concerned about the man's mood.
42. The friend said he was worried about the man because he seemed very down after his telephone conversation and was “not his usual self”. The friend said that he wanted to speak to a member of unit staff about the man and so, at about 6.40pm, he went to find the senior officer who was in charge of the unit that day. The friend said that, when he got the unit office, another prisoner was also waiting to see the senior officer who told them both that it was time for lock up and that they should return to their cells.
43. The senior officer was also interviewed as part of this investigation. He confirmed that the man's friend had come to his office on the evening of 27 August, just as lock up had been announced. He could not remember what the friend had said to him but recalled that he told him and another prisoner, who also wanted to see him, that they should return to their cells. The senior officer told my investigators that it was quite common for prisoners to come to the unit office as lock up was being called to make applications, and that there was a set time for doing this. He said that there was nothing in the friend's behaviour or manner to suggest that he urgently needed to speak to staff and, when told to

return to his cell, he did so. The senior officer told my investigators that if the friend had said that it was urgent, or if he had been more persistent, he would have made time to talk to him before he was locked in his cell. The friend confirmed that he had not told the senior officer why he wanted to see him.

44. At about 6.45pm, staff on unit 5/6 began locking prisoners in their cells for the night. A prison officer was responsible for locking up prisoners on the man's corridor. In interview, she said she remembered locking the man in his cell that evening. He was lying on his bed, with his arms behind his head. As she locked his door she said, "Goodnight" and he replied, "Goodnight, Miss." The officer said she had been over the events of that night many times since the man had died, but thought that he had seemed his usual self and had given her no cause for concern.
45. The man's friend was not in his cell when the officer initially came to lock his door, so she continued locking the rest of the cells on the corridor and returned to his cell last. When she returned, he was standing at the doorway waiting for her. The friend said that when the officer came to his cell, he pulled her by the arm into his cell. He said that he was worried about the man and asked her to "keep an eye on him". He said that she nodded and locked his door. In interview the friend explained that he had not told the officer and she had not asked, why he was worried about the man.
46. The officer said that after she had locked the friend's door she returned to the unit office and spoke to the senior officer about what the prisoner had said to her. She explained to him that she had just seen the man when locking his door and that he had seemed fine. In interview the officer said that if she had felt concerned about the man she would have returned to his cell to talk to him. She said she would have done this even though her shift was nearing the end and it was time for lock up. She felt that she would have been supported by her colleagues if she had wanted to spend extra time making sure he was okay.
47. As a result of their conversation the senior officer checked the man's file to see if there were any concerns or issues noted. There was nothing in the file to suggest that staff should be unduly concerned about him. He decided that one of the man's personal officers should speak to him the following day and check that he was okay. The officer who had locked the cells said that one of the man's personal officers was in the office while she and the senior officer were discussing the man and she made sure he was aware of her conversation with the man's friend. The man's personal officer was responsible for handing over to the evening staff and, according to the officer who locked the cells, said he would tell them about the man. The man's personal officer told my investigators he had no recollection of such a conversation and did not remember hearing any concerns about the man.
48. Another officer was on duty on unit 5/6 between 6.45pm and 9.00pm on 27 August. He told my investigator that day staff normally went off duty at about 7.00pm, and that a handover of information from day staff to evening staff was carried out at about 6.45pm. He explained that the handover normally included information on those prisoners on an ACCT document (Assessment, Care in

Custody and Teamwork – the process by which prisoners at risk of suicide or self harm are supported and monitored) and those on the basic level of the Incentives and Earned Privileges (IEP) scheme. (The IEP scheme is designed to encourage and reward good behaviour whilst in prison. There are three levels – basic, standard and enhanced. Prisoners on basic level have the lowest number of privileges.) The handover should also include those being monitored or supported for other reasons. The officer explained that this was also the point at which more general concerns about specific prisoners could be discussed. He told my investigator that he could not recall being told that there were any concerns about the man that night. The handover sheet (which should be signed by the officer handing over information and the officer receiving the information) was not signed to indicate that the 6.45pm handover had taken place. The officer cannot recall who was responsible for handing over to him that night.

49. The officer was also asked about the purpose of the Staff Observation Book, one of which can be found on each unit within the prison. He explained that it provides a written record of any information that might be useful to other staff working on the unit. He said that, if staff are worried about a particular prisoner, they can use the Staff Observation Book to inform all staff about this. No entries were made in the Staff Observation Book for unit 5/6 on 27 August reflecting the man's friend's concerns, or indicating that staff should speak to the man the following day.

50. An officer support grade (OSG), who had 19 years experience at the prison, was on duty on unit 5/6 on 27 August. The night shift formally begins at 9.00pm, but the OSG and the officer working from 6.45pm until 9.00pm confirmed that night staff usually arrive on the units by 8.40pm so they can receive a handover before the evening staff go off duty. The OSG was asked what sort of information is usually passed on in the handover and he explained:

“[If] they have had problems with someone during the day and they say he may play up during the evening or at night, once they know that there is just one [member of staff] on. There may be concerns that somebody has been upset about something, they may have had a bad visit or something like this, it may have been all sorts of problems really.”

51. That night, the officer working from 6.45pm until 9.00pm was responsible for the handover to the OSG. He was not aware of any concerns about the man and so did not mention him during the handover. The OSG told my investigators that night staff “sometimes got a whisper off the other prisoners” if they had concerns about someone, and that they might ask staff to check on them during the night. No prisoners spoke to the OSG about the man that night.

52. Unit 5/6, which houses 80 prisoners in single cells, is staffed by a single OSG overnight. The OSG's responsibilities include ensuring all the cell doors are locked, monitoring prisoners on ACCT documents and other intervention plans, answering cell bells during the night, checking fire equipment and patrolling the unit. On 27 August 2008, Edmunds Hill had no prisoners on ACCT documents.

53. In interview, the OSG was asked whether all prisoners were checked on during the night. He explained that day staff carry out the last roll check of the day (when all the prisoners are counted to make sure all have been accounted for) at 7.30pm. Night staff are not required to perform a count or physical check of all prisoners on the unit themselves. The OSG confirmed that night staff do not check on individual prisoners unless they are on an ACCT document or specific concerns have been raised about them. He said that prisoners were only checked if there was a reason to do so. However the OSG added that, if prison staff had concerns about particular prisoners and had asked night staff to keep an eye on them, they would:

“... try to do a sort of unofficial look in on them. If I know he has been passed over to me, normally when we go round checking the doors, if a flap [has] been left open on a window we will close it, but in his ... case we would look in just to see what he is doing at the time or whatever, might speak to him and say are you alright, he will nod, wave or swear at you or whatever he wants to do, but that sort of thing.”

54. As the OSG had not been informed of any concerns about the man and he did not press his cell bell during the night, he was not checked on between 6.45pm on 27 August and roll check at 7.30am the next morning.

55. My investigators also asked the OSG and prisoners on unit 5/6 about the use of cell bells during the night. The OSG said that, whilst the cell bells were intended for emergency use, prisoners use them for a variety of non-urgent reasons. He thought that prisoners were very comfortable about using the cell bells. This was confirmed by two prisoners who were interviewed during the investigation and who said that prisoners were confident in using their cell bells if necessary.

56. Prisoners on the man's corridor explained how they would often talk to each other after being locked up by shouting through their doors. The man's friend told my investigators about his efforts to speak to the man after lock up that night. He explained that at about 9.40pm he called out to him, as he often did, to talk about the television programme, *Big Brother*, which they both used to watch. He called several times but got no response. At this point a prisoner in the cell next to the man told the man's friend that he had been trying to speak to him since about 8.00pm and that he must already be asleep. The man's friend said that he fell asleep shortly after that and heard nothing unusual during the night.

57. The OSG recalled the night of 27 August as being one of the quietest he had ever experienced at Edmunds Hill, with only two cell bell calls all night. He explained that he walked around the whole of the unit several times during the night shift, at intervals of not less than 40 minutes and not more than one hour and 20 minutes.

58. Overnight, Edmunds Hill is managed by the Night Orderly Officer (NOO) and three other officers who visit each unit of the prison several times during the night to supervise and support the OSGs on the units. The Night Orderly Officer in charge of the prison that night was interviewed. She explained that as part of her responsibilities, she made rounds of the prison and arrived on unit 5/6 at

12.05am. She told my investigators that she spoke with the OSG whilst on the unit and he had nothing to report.

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59. Three officers (including the man's personal officer) had all arrived at the prison ready to begin work at 7.30am. The OSG went off duty and left the prison. The man's personal officer began the roll check on the unit and asked one of the other officers to carry out the count on the top landing (where the man's cell was located). The officer reached the man's cell (number 6:21) and opened the observation flap in the door. He saw him standing by the window, facing the cell door, with something tied around his neck. He described the man as "slumped with his chin on his chest, his arms dangling next to him". On seeing him, the officer said he was quite sure that he was dead.
60. Edmunds Hill Local Instruction 2.100, dated 3 March 2008, sets out the protocol for entering cells during the patrol state. According to the instruction, under normal circumstances at least two members of staff should be present when a cell is opened. Where there is, or appears to be, immediate danger to life, cells may be opened by one member of staff and without the authority of the Orderly Officer, although the control room must be contacted before such action is taken.
61. The officer conducting the roll check on the top landing used his radio to put out a 'Code Blue' call, which alerts healthcare staff that assistance is needed for someone who is not breathing. He radioed for permission from the Orderly Officer to enter the cell. He had not yet received a response from the Orderly Officer when the other two officers arrived on the landing and they went into the cell together.
62. The man's personal officer explained that he had continued the roll check on the ground level of unit 5/6 and had reached the cell directly under the man's. When he heard the Code Blue call for the cell on the upper landing, he quickly ran up the stairs. The personal officer heard the officer conducting the roll check on the top landing calling for permission to enter the cell and knew it must be a serious situation. On arriving at cell 6:21, he looked through the flap and saw the man hanging from the top right hand corner of his window. He had used a piece of his bed sheet to make a ligature.
63. Within seconds a third officer also arrived on the corridor and shouted to the two officers to enter the cell. The officer who had been conducting the roll check on the top landing opened the man's cell with his keys while the man's personal officer took out his anti-ligature knife (a knife specially designed to cut ligatures safely which is carried by all operational staff at the prison). All three officers then went into the cell. The man's personal officer took hold of the man's body and cut the ligature from around his neck. He explained to my investigators that the man's body was "cold and rigid" and it was clear that he had been dead for some time. Staff could see that rigor mortis had set in and so they did not lay his body on the floor.

64. In interview the third officer said that he made the decision that there was nothing that could be done to revive the man and that they should leave the cell. He was asked whether anyone checked him for a pulse at this point, and he explained that they had not as they believed that he had been dead for some time.
65. Both this officer and the man's personal officer said that they would have felt confident beginning cardio-pulmonary resuscitation (CPR) if they had needed to. The man's personal officer had received up to date first aid training, whilst the other two had received some training in the past although this was now out of date.
66. On leaving the man's cell, the officer who had been conducting the roll check on the top landing went to the unit office and the third officer went to speak to the prisoner in the cell opposite. The prisoner had heard the Code Blue call and was very upset. The man's personal officer remained outside the man's cell and healthcare staff arrived.
67. Two nurses (including the one who had carried out the first reception healthscreen) had arrived at the prison at about 7.20am and were in the healthcare centre when they heard the Code Blue call over their radios. Accompanied by an agency staff nurse, they grabbed the emergency equipment and made their way to unit 5/6. One of the nurses told my investigators that she took the emergency resuscitation bag, which contains all the equipment necessary to begin resuscitation. The other two brought the defibrillator and oxygen. The nurse who took the emergency equipment also told my investigators that she always carries resuscitation equipment in a small pouch attached to her belt so she can begin working on a patient even if she does not have the emergency bag from healthcare.
68. Unit 5/6 is some distance from the healthcare centre at the prison and the nurse who carried out the first reception healthscreen estimated that it had taken them about five minutes to reach the unit. Healthcare staff carry keys, so they were able to head to the unit immediately on hearing the Code Blue. The nurse carrying the emergency equipment arrived on the corridor first and followed other staff who were running towards the man's cell.
69. The nurse with the emergency equipment went into the cell and saw the man standing by the window. She noticed his arms and legs were blotchy, and when she touched his body he was cold. She recognised that rigor mortis had set in and was sure that he had been dead for some time. Nevertheless the nurse checked for a pulse and any sign of life. She found none. The nurse who had conducted the first reception healthscreen also entered the man's cell and agreed that there was nothing they could do.
70. The incident log, compiled by a member of staff in the communications department, indicates that an ambulance was called by the staff there at 7.38am, following the Code Blue radio call. The paramedics pronounced the man dead at 8.05am.

Prisoner support

71. The man had a number of friends with cells near to his, several of whom had heard the officer make the Code Blue call. Those interviewed by my investigators said that they knew the man had died without being told so by a member of staff. However, they said that staff had come to them in person and told them the news of his death.
72. Prisoners living on the man's corridor were 'buddied up' (put in cells together or with other friends and family in the prison) later that morning, so they could comfort and support each other. Members of the prison chaplaincy team visited the unit and prisoners were offered the chance to speak with them, or with Listeners (prisoners trained by the Samaritans to offer a confidential support service to other prisoners), or with members of staff. One of his friends was placed on an ACCT document that day.
73. Prisoners on unit 5/6 and across the prison organised a collection and wreath for the family. They were also invited to write down prayers and thoughts in the chapel, which were sent on to the man's mother.

Contact with the man's family

74. The man's mother was informed of her son's death by local police on the morning of 28 August. Edmunds Hill did not have any trained family liaison officers in post on 28 August but a governor was appointed to liaise with the family. This was his first experience of family liaison. He maintained regular contact with the man's mother. Members of the man's family were given the opportunity to see his cell when they came to the prison to collect his belongings.
75. The man's mother told my family liaison officer that the prison had not offered her any financial assistance with the man's funeral expenses. She also said that she had not been sent a letter of condolence from the Governor. It appears that the Governor and the family liaison officer thought that an offer of financial assistance had been made, albeit not explicitly, in a letter sent to the man's mother shortly after his death. This issue was raised by our investigator with the Deputy Governor, who ensured that a clear offer of financial assistance was made to the mother. The prison provided my investigator with a copy of the letter of condolence they had sent to the mother of the man shortly after his death.

Staff support

76. The Governor did not hold a hot debrief on the day of the man's death but instead thought it more appropriate to talk to members of staff involved individually. (A hot debrief is a meeting of staff involved in a traumatic incident to establish the events, identify any immediate learning points, and allow those involved to share their thoughts and feelings. It is a requirement of Prison Service Order 2710.) He then called a full staff meeting at lunchtime to tell staff about the man's death. Several members of staff who had been involved in responding to the Code Blue call decided not to attend the full staff meeting, fearing that they would be subject to too much attention from their colleagues.

77. Generally, prison staff involved said that they felt well supported by the prison. The majority said that members of the prison's care team made contact with them immediately following the man's death. However the nurse who had brought the emergency equipment and a senior officer (who responded to the Code Blue call) told my investigators that they had felt "forgotten" in the aftermath of the death. Neither had been asked to make an incident statement, nor had spoken to the Governor on the day of the man's death, nor been offered support from the care team. They were not invited to attend the Critical Incident Debrief, which took place several weeks later.
78. As noted above a governor had acted as the prison's family liaison officer. He told my investigators that he had been well supported by senior management at the prison, but had not been contacted by the prison's care team. He felt that this extra support would have been useful to him.

ISSUES CONSIDERED DURING THE INVESTIGATION

The man's recall to prison

79. The man had been released from prison in 2007 on licence and was recalled, having breached his licence conditions, in July 2008. His criminal defence solicitor told my investigator that at the time of his death they were in the process of appealing against the recall decision. She explained that he fully understood why he had been recalled and when he would be released. I am pleased that this was the case and that both Pentonville and Edmunds Hill, most likely helped by the input of the man's solicitor, appear to have provided him with clear information about his recall.
80. Whilst at Edmunds Hill, it seems that the man fully engaged in the regime. He was attending education and steps were being taken to find him a job in the prison. I believe that, whilst his recall was undoubtedly a source of frustration for him and the reason he was separated from his family, there is no evidence to suggest that it directly contributed to his death.

Clinical care

81. Suffolk PCT commissioned a clinical review of the care given to the man whilst he was at Edmunds Hill. The reviewer had access to the man's clinical records and statements from staff, and undertook joint interviews with my investigator.
82. The clinical review found that there were gaps in record keeping with some signatures and various entries missing from his clinical record. Such gaps might be partially resolved by the introduction of a clinical computer system at the prison. The clinical reviewer has made the following recommendation which I endorse:

The Head of Healthcare should offer additional training in record keeping to staff.

83. Various documents contained within the man's prison file make mention of his past history of depression, paranoia and personality disorder. A report written by his probation officer in November 2007 recorded that he had attempted to self harm in the past. Healthcare staff at Pentonville, who assessed him on his recall to prison, noted his history of depression but found that he was of "normal mental state" and had no current thoughts of harming himself. Whilst at Edmunds Hill he was assessed first by a nurse in reception, then by a prison doctor, and then by the mental health nurse who carried out a mental health screen.
84. The man told healthcare staff at the prison that he had no current thoughts of self harm or suicide and denied feeling depressed. The mental health nurse found him to be positive and motivated.
85. The clinical reviewer considered whether healthcare staff had reasonably assessed the man's risk to himself and concluded that:

“From his Clinical Records and interviewing staff it is clear that at no time did he give any cause for concern, either verbally or through his behaviour.”

86. The clinical reviewer is satisfied that staff at Edmunds Hill properly assessed the man’s mental health whilst he was at the prison. While he had a history of depression and there were indications that he had tried to harm himself in the past, staff reasonably concluded that there was no current evidence to suggest that he was thinking of harming himself or taking his life.

Response to prisoners’ concerns about the man

87. Following the man’s telephone conversation with his wife shortly before lock up on 27 August, some of his friends on unit 5/6 were concerned about him. The man’s friend asked the officer locking the unit that night to “keep an eye” on him. The officer discussed this with the senior officer, who looked through the man’s file for any areas of concern. On finding none, he decided that staff should speak to the man the next day to check his welfare.
88. I have considered whether the staff’s response to the man’s friend’s concerns was reasonable and appropriate, given the available evidence. The friend said that he did not explain the nature of his concerns about the man to either the officer or the SO. He had not told anyone about the man mentioning suicide in a previous conversation. Staff did not feel they knew the man well. But there were no indications that he was vulnerable or at risk of harming himself. The officer locking the prisoners up that night appropriately discussed the issue with SO, who correctly checked the man’s file for indications of concern. Their interviews with my investigators indicated that they had given proper consideration to what action should be taken in response.
89. However, my investigators identified that the process for passing on concerns about prisoners between staff is not sufficiently rigorous. Although the SO and the officer were satisfied there was no immediate cause to worry about the man, the information should have been passed on to staff coming on duty that evening and night. An entry should have been made in the Staff Observation Book reflecting the concerns raised about the man and the need for staff to check on him the following day. Similarly, an entry should have been made in his wing history record. The daily handover sheet should have been signed by staff giving and receiving the handover information.

The Governor should remind staff of the importance of making quality entries in the Staff Observation Book and in prisoners’ files, and of the importance of properly handing over information at the end of each shift and signing the daily handover sheet.

Checking prisoners overnight

90. At Edmunds Hill, the last roll check of the day takes place at 6.45pm. Staff working on the units in the evening and overnight do not carry out a roll check of their own, and the next one takes place at 7.45am. Night OSGs, who staff the units overnight, are expected to check that all the cell doors are locked when they come on duty. They must check on prisoners on ACCT documents and those who need to be checked for any other reason, as directed. However, prisoners who are not being supervised under any intervention plan will not be checked during the night. The man's family were concerned that he was not visibly checked by staff for over 12 hours.
91. During the course of this investigation, Prison Service Headquarters was approached for information regarding the timing of roll checks. The National Security Framework requires that four roll checks are made during any 24 hour period. The exact timing is at the discretion of the Governor of each establishment, although there is an expectation that one roll check will be undertaken in the morning and one in the evening.
92. The timing of roll checks at Edmunds Hill complies with these directions. Given that the man was not on an ACCT or requiring supervision for any other reason, there was no requirement for staff to check him overnight. I appreciate that this will be of little comfort to the man's family, but I do not think there are any grounds for criticising the prison. It would not be proper for prisoners to be checked throughout the night unless there is good reason for doing so.
93. The man's mother had sight of the draft report. She remains concerned that her son was not checked for over 12 hours and considers that the processes for checking on prisoners overnight are not sufficient.
94. I was concerned to learn, however, that the OSG who was on duty on unit 5/6 overnight on 27 August, left the prison before the roll check was carried out and found correct on 28 August. The establishment's Night Orders for OSG Night Patrols direct that they:
- “... Must not leave the unit until the member of staff coming on duty has satisfied themselves that the unit roll is correct, all gates/doors are secure and any prisoners on ACCT have been checked.”
95. Staff have confirmed that it is not uncommon practice at Edmunds Hill for OSGs to leave the establishment before such checks are done. On this basis the OSG cannot be individually criticised. However, if he had not already left the prison he would have been there when the man was found. This reinforces my earlier recommendation about the importance of properly handing over between shifts. My investigator has been assured that the practice is currently being looked at by senior management at the prison, and a procedure is to be introduced to ensure that night staff remain on their unit until the roll has been found to be correct.

The prison's response to the man's death

96. The death of the man was the first to have occurred at Edmunds Hill since it became a male establishment. Staff at the prison have little previous experience of dealing with deaths in custody. I am pleased to find, therefore, that the staff response to finding the man hanging was prompt and efficient. The prison's local instructions allow for a single member of staff to enter the cell in life threatening situations without the permission of the Orderly Officer. The officer undertaking the roll check on the top landing initially radioed for permission to enter the cell. However, when two other officers arrived on the landing, they instructed the officer to go into the cell. I am satisfied that staff acted quickly but safely.
97. All staff who went into the man's cell and saw his body agreed that it was clear that he had been dead for some time. I agree that under such circumstances it was not appropriate for CPR to be attempted. However, during the course of the investigation, it became clear that there is currently no rolling programme of first aid refresher training for staff at Edmunds Hill. This means that there may be times when none of the operational staff on duty has in-date first aid training. Given that the prison does not have 24-hour healthcare cover, this is likely to be of particular concern overnight and could have very serious consequences. I am aware that there are plans to ensure that all Senior Officers are given first aid refresher training, although there is no timescale for their implementation. With this in mind, I make the following recommendation:

The Governor should put in place a rolling programme of first aid refresher training for all Senior Officers in the prison within a specified timescale.

98. The nurse who carried the emergency equipment told my investigators that she routinely carries a small pack, attached to her belt, which contains all the equipment she would need to begin CPR in an emergency when the medical bag has not yet arrived. I am pleased to highlight this example of good practice.

It is good practice for healthcare staff to carry emergency resuscitation equipment at all times.

99. The man's friends on unit 5/6 were treated with proper consideration. They were told of the man's death and quickly offered the support of the chaplaincy team, Listeners and prison staff. They were then moved into cells with other friends or family. Shortly after his death, prisoners organised a collection for a wreath and were able to attend a memorial service in the prison chapel.

Compliance with Prison Service Order 2710

100. The prison's death in custody contingency plans were activated promptly and carried out efficiently. Generally, staff who knew the man or who had responded to the Code Blue call on the morning of 28 August felt well supported by senior management at the prison. Although no hot debrief was held, the Governor spoke with most staff individually in the hours following his death because he felt

this to be more appropriate. A full staff meeting was then held at lunchtime on 28 August to inform the remaining staff present of his death.

101. Prison Service Order (PSO) 2710 (Follow up to deaths in custody) instructs that “[t]here must always be a hot debrief immediately after the incident”. Italicised sections of PSOs are mandatory. However, in this instance I am satisfied that the decision not to hold a hot debrief was a considered one, and speaking to staff individually provided an opportunity to reassure and support them. However, the purpose of a hot debrief is also to identify learning points that might prevent another death occurring. This learning may be best identified in a group setting and through discussion.

102. Having seen the draft report, the Governor provided the following information:

“The Silver command suite was shut at 12:00hrs and I arranged a hot debrief in the visits hall for 12:45hrs. I met with the individual members of staff who were first on the scene between 12:00 and 12:45 and some of them asked if they could be excused debrief. I felt this was appropriate. I extended the debrief to all staff as there were many departments involved in passing messages to prisoners or moving prisoners to the chapel and this may be why the PPO describes a “full staff meeting”. The debrief did more than inform staff of what had occurred. Staff were given an opportunity to share their thoughts, we discussed learning points and staff highlighted colleagues who had been particularly involved or who had done a particularly good job that morning. I also informed staff of the support that would be on offer for them and the prisoners.”

103. The majority of staff involved were contacted by the prison’s care team immediately following the man’s death. However, two members of staff who were not identified as having responded to the Code Blue felt they had not received support from the prison. They did not speak to the Governor on the day of the man’s death, did not speak to anyone from the care team, and were not invited to attend the Critical Incident Debrief held several weeks later.

The Governor should ensure that procedures are in place to identify all staff involved with a serious incident.

104. Prior to the man’s death, Edmunds Hill did not have any trained Family Liaison Officers in place. The supplementary guidance to PSO 2710 dealing with liaison with bereaved families states that either a trained FLO or a senior member of staff should be appointed. A governor was appointed to undertake the role late in the morning on 28 August, but had never done so before and had not had any formal training. He received some limited instructions from the trained FLO at HMP Highpoint, which is just across the road from Edmunds Hill.

The Governor should identify suitable staff to undergo the Prison Service family liaison training as a matter of urgency.

105. News of the man’s death was broken to his mother by police officers local to her home. PSO 2710 indicates that it is preferable for prison staff to visit family

members rather than police. However, the Governor explained to my investigators that he was concerned that news of the man's death would spread quickly around the prison and a friend or acquaintance of him might contact the family first. On this basis, and given that the man's family did not live locally, he decided that it was most appropriate for the police to visit the family. Under PSO 2710, prisons are encouraged to identify local prison staff who can break the news to the family. Use of the police should be a last resort. The Governor will wish to bear this in mind in the event of any future death in the prison.

106. The prison provided my investigator with a copy of the letter of condolence sent by the Governor to the man's mother. The prison FLO said they had also sent some written information for bereaved families. However the man's mother said she had not received a letter of condolence and was not clear that she was entitled to financial assistance towards the cost of her son's funeral. It appears that an offer of assistance was made, but it was not sufficiently explicit to be clear to the man's family. Once told of the confusion, the prison arranged for the payment towards the funeral costs. However, no one from the prison offered to attend the funeral, which is recommended in the supplementary guidance to PSO 2710.
107. The family liaison officer told my investigators that he had received good support from senior management at the prison but was not contacted by members of the care team. Given the nature of the role of the FLO, it is important that they are offered support from the care team and that this is on an ongoing basis.
108. In view of the rarity of deaths at Edmunds Hill, I suggest that the Governor arranges for Contingency Planning Exercises to be held.

The Governor should ensure that the prison complies with the requirements of PSO 2710, Follow up to a death in custody, particularly regarding:

- **Holding a hot debrief for all the staff involved.**
- **Making a clear offer of financial assistance for the funeral costs.**
- **Appointing trained family liaison officers who are supported whilst they carry out their duties.**
- **The supplementary guidance regarding liaison with the bereaved family.**

CONCLUSION

109. The man appeared to have settled in well to the routine at Edmunds Hill and he gave no cause for concern throughout his six weeks there until the night before his death. Although staff were told that there were some concerns about him, this information was not included in any record. There were no indications on his wing record that he might try to harm himself so no additional safeguards were put in place to support him on the night he died.
110. My investigation has identified a number of ways in which Edmunds Hill can improve its response to indications of concern, not least by improving the record keeping and transfer of information between staff. However, I do not believe that the man's actions could reasonably have been foreseen. Nor do I think that any of the recommendations I have made would have prevented the man from taking the actions he did.

RECOMMENDATIONS

1. The Head of Healthcare should offer additional training in record keeping to staff.

The Prison Service accepted this recommendation.

2. The Governor should remind staff of the importance of making quality entries in the Staff Observation Book and in prisoners' files, and of the importance of properly handing over information at the end of each shift and signing the daily handover sheet.

The Prison Service accepted this recommendation. A notice to staff has been issued.

3. The Governor should put in place a rolling programme of first aid refresher training for all Senior Officers in the prison within a specified timescale.

The Prison Service accepted this recommendation. The response was:

"Edmunds Hill has since developed its own training department and a new programme has been developed, first aid as a priority."

4. The Governor should ensure that procedures are in place to identify all staff involved with a serious incident.

The Prison Service accepted this recommendation. A new set of contingency plans have been written to ensure this occurs.

5. The Governor should identify suitable staff to undergo the Prison Service family liaison training as a matter of urgency.

The Prison Service accepted this recommendation. A Family Liaison Officer has been appointed and trained.

6. The Governor should ensure that the prison complies with the requirements of PSO 2710, Follow up to a death in custody, particularly regarding:

- Holding a hot debrief for all the staff involved.
- Making a clear offer of financial assistance for the funeral costs.
- Appointing trained family liaison officers who are supported whilst they carry out their duties.
- The supplementary guidance regarding liaison with the bereaved family.

The Prison Service accepted this recommendation.

GOOD PRACTICE

It is good practice for healthcare staff to carry emergency resuscitation equipment at all times.