Investigation into the circumstances surrounding the death of a man on 12 July 2011, whilst in the custody of HMP Gloucester

Report by the Prisons and Probation Ombudsman for England and Wales

April 2012

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.

This is the report of an investigation into the death of a prisoner at HMP Gloucester who died on 12 July 2011. He was 34 years old. The man was discovered by his cell mate, when he returned from exercise, hanging from the bars in their shared cell.

I offer my sincere condolences to the man's family and to all those affected by his death.

The investigation was undertaken by one my senior investigators. I would like to thank the Governor of Gloucester and her staff for their assistance during the investigation. I am sorry that this report has been slightly delayed.

A clinical review into the man's medical care at Gloucester was commissioned from Gloucestershire Primary Care Trust. They appointed a doctor to conduct the review and I am grateful for his report. The clinical reviewer concludes that the man's clinical care was "at least as good as would have been expected of a patient in the community and probably better than he would have received".

The man had significant alcohol and mental health issues and he was supported by both staff in the community and in HMP Gloucester. When he was last in custody, the man had been subject to self-harm and suicide observation for a short period. However, on his return to custody, in May 2011, the man appeared willing to engage with the support organisations and appeared to have turned a corner. Both my investigator and the clinical reviewer conclude that he gave no cause for concern with regard to self-harm or suicide in the period leading up to his death. All those who knew the man, prisoners and staff alike, were shocked that he apparently took his own life. As his tragic death was not foreseeable, I make only one recommendation regarding the need for staff to make better checks on prisoners when they are unlocked, although there is no evidence that these would have altered the outcome in the man's case.

The recommendation made in the draft report has been accepted by HMP Gloucester I have included the prison's response to the recommendation at the end of this report.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **April 2012**

SUMMARY

1. The man was born in 1977. He was 34 years old when he died on 12 July 2011 at HMP Gloucester. The man was found hanging by his cell mate when he returned to their shared cell. He had attached a ligature made from a bed sheet to the window bars in their cell.

2. On 13 May 2011, the man was remanded into the custody of HMP Gloucester by Magistrates' Court after being charged with harassment. He was located on A wing in a double cell (A3-09). The man had been previously released from Gloucester just less than two months earlier, on 15 March. During his first reception health screening interviews, it was recorded that he had history of alcohol dependency and had received mental health support whilst in the community. He received support for both his alcohol dependency and mental health needs whilst he was in custody.

3. During the man's previous time in custody at Gloucester he was subject to a self-harm observation and support plan. This involved regular checks being carried out and recorded. The plan was closed within a few days of being started when the risk of self-harm and suicide was assessed to have lessened. On his return to Gloucester, on 13 May, the man appeared to be much more settled than on his previous times in custody. Therefore, it was decided not to open a self-harm observation and support plan.

4. On 7 July, the man was sentenced to 20 weeks imprisonment at Magistrates' Court. He was to be released from custody on 28 July due to the time he had already served on remand.

5. Around 11.00am on 12 July, staff opened the man's cell and he was offered the opportunity to go on exercise. The man's cell mate took up the offer but the man declined to go on exercise, so he was locked in the cell alone. When his cell mate returned from exercise at around 12.15pm, he discovered the man unconscious and suspended by a ligature from the window bars in their shared cell. The man's cell mate informed staff who cut the ligature and summoned medical assistance. Healthcare staff attended and attempted to resuscitate the man. When paramedics arrived they took over the man's care. Unfortunately the attempts to resuscitate him were unsuccessful and the man was pronounced dead at 12.49pm.

6. The clinical review carried out on behalf of Gloucestershire Primary Care Trust, considered both the care provided for the man throughout his time in prison and the emergency response when he was found hanging. In the clinical reviewer's view, the quality of care given to the man was "probably better" than what he would have received in the community. We have also concluded that staff used the self-harm observation and support processes appropriately and that the man's death was not foreseeable.

7. We make only one recommendation regarding the need for staff to make better checks on prisoners when they are unlocked, although there is no evidence that these would have altered the outcome in the man's case.

THE INVESTIGATION PROCESS

8. The investigator was formally notified of the man's death on 13 July 2011. Notices were subsequently issued to both staff and prisoners at HMP Gloucester to inform them of the investigation process and asking anyone who had information relevant to the investigation to contact the investigator. In the event, no one came forward. The investigator also studied all the relevant prison records relating to the man which included his main prison record and his medical records.

9. A clinical review was commissioned from Gloucestershire Primary Care Trust into the care provided for the man during his time in custody. The purpose of the review was to establish whether the care which the man received in prison was comparable with that he would have been offered in the community and to identify any points of learning. A doctor was appointed to lead the clinical review. We are grateful for his report which was received on 10 October 2011 and is annexed to my report. We apologise for the delay in issuing the draft report. This was due to work pressures at the Ombudsman's office.

10. The investigator contacted Her Majesty's Coroner to inform him of the nature and scope of the investigation and to request a copy of the post mortem report. Upon completion, this report will be sent to the Coroner to assist his enquiries into the man's death.

11. One of our family liaison officers contacted the man's family. They were informed about the purpose of the investigation and offered the chance to raise any concerns or questions that they wanted to be addressed. The man's family did not raise any issues at the outset of the investigation. The man's family received a copy of the draft report as part of the consultation period. In their response they commented that the report had provided them with a better understanding of the circumstances of the man's death. They accepted the findings of the investigation and did not wish to raise anything further. We are grateful to the man's family for their consideration of the report.

12. The investigator visited HMP Gloucester on 19 July and spoke to the Governor and a member of the Independent Monitoring Board[1] as well as other staff involved in the care of the man. He returned on 2, 3, 16 and 17 August and 20 September. He conducted joint interviews with the clinical reviewer. Transcripts of these interviews are attached to this report. After completing the interviews, Mr Del-Greco discussed the emerging issues with the Governor of Gloucester, on 17 August, and later confirmed his findings in writing.

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[1] The Independent Monitoring Board (IMB) is appointed by the Secretary of State for Justice from unpaid volunteer members of the community. Their role is to satisfy themselves that the prisoners are treated humanely and justly and that there are adequate programmes for preparing prisoners for release.

HMP & YOI GLOUCESTER

13. HMP& YOI Gloucester is an adult male prison and young offender remand centre. It is an old Victorian prison in the centre of Gloucester and has an operational capacity of 321 prisoners. Part of the accommodation dates back to the eighteenth century. The prison is established to serve the Crown Courts of Gloucester and Hereford together with the associated magistrates' courts. In practice, prisoners come to HMP Gloucester from a far wider area.

14. Gloucester provides 24 hour healthcare cover with inpatient facilities for eight prisoners. At night healthcare is staffed by nurses supported by on call doctors. Healthcare is located in a separate two-storey building, equipped by Gloucestershire PCT. It has an assessment and treatment unit, including the inpatient facilities upstairs, outpatient facilities downstairs, and a hot food servery for inpatients.

15. Since the Ombudsman office took over responsibility in 2004 for investigating all deaths in custody, there had been ten deaths at Gloucester prior to that of the man. Five of these were apparently self-inflicted with the others attributed to natural causes. Aside from the method used (hanging by ligature is the most common form of self-inflicted death in prisons), there were few similarities between the man's death and those of other prisoners.

Insiders and Listeners

16. Gloucester recruits experienced prisoners to operate as Insiders and Listeners. Insiders welcome new prisoners, highlight any concerns and explain the processes they will encounter in the early days of custody.

17. Listeners support prisoners who may be at risk of suicide or self-harm. They are selected, trained and supported by the Samaritans to offer confidential emotional support 24 hours a day, to fellow prisoners in distress. The Listeners scheme is confidential and any prisoner can ask to speak to a Listener any time of the day or night.

Assessment, Care in Custody and Teamwork (ACCT)

18. The ACCT system monitors and supports prisoners who are assessed as at risk of suicide or self-harm. It is a flexible, prisoner-centred assessment and care planning system, which aims to identify individual needs and offer personalised care and support before, during and after crisis, in a safe and caring environment. Once placed on ACCT support, the prisoner is observed at intervals determined by their perceived level of risk. The observations continue during the day and the night. Additional support is offered from Listeners, personal officers[2] and other staff. Amongst other things, the ACCT guidance states that prisoners should be cared for in a safe environment. The arrangements are reviewed regularly by a multi disciplinary meeting, which should include the prisoner.

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[2] Each prisoner is allocated a personal officer, who is the first point of contact for them.

HM Chief Inspector of Prisons

19. HM Chief Inspector of Prisons last conducted an announced inspection of the prison August 2010. The Chief Inspector noted that:

> "Gloucester is a prison that causes concern. It has deteriorated since our last inspection [2007]. It is a very poor physical environment and there is evidence of a downward drift in performance across a range of areas. It needs urgent attention."

Independent Monitoring Board

20. The Independent Monitoring Board (IMB) is appointed by the Secretary of State for Justice from unpaid volunteer members of the community. Their role is to satisfy themselves that the prisoners are treated humanely and justly and that there are adequate programmes for preparing prisoners for release. The IMB report directly to the Secretary of State if they have any concerns. They also submit annual reports on how the prison has met the standards and requirements placed on it. Members of the IMB have access to every prisoner, every part of the prison and every prison record. The last annual report published by the Gloucester IMB covers the period from October 2009 to November 2010. The Board noted that:

> "Provision for Secondary Mental Health (severe mental illness including learning disabilities) is supplied by the In-Reach team who liaise with General Practitioners (GPs) and community psychiatric nurses (CPNs) and accept referrals across the prison establishment. Such referrals are indicative of the cooperative working that occurs between Mental Health staff and their prison officer colleagues, an approach underlined this year by the distribution throughout the prison of a general leaflet on Mental Health produced by In-Reach… The team has continued to have a high rate of 30 referrals a month, all of whom are seen within 3 working days… The work of the In-Reach team was recognised during the year by an award for "Positive Practice" by the 2gether Trust, and the team achieved a score of 96% in the audit of its Care Programme Approach (CPA). The good practice extends to keeping in contact as appropriate with released patients on the In-Reach caseload. This practice has shown dividends with difficult cases known to the Board, and helped to ensure rapid transfer from prison when indicated - all transfers have been within the national guidelines and in one case was achieved in 3 days due to the continuity of contact both with the prisoner and outside agencies."

KEY EVENTS

21. The man was born in 1977 in Poland. He was 34 years old when he died on 12 July 2011 at HMP Gloucester.

22. The man was released from Gloucester on 15 March 2011. Just under two months later, on 13 May, he was remanded into custody by Gloucestershire Magistrates' Court, having been charged with harassment, and he returned to Gloucester prison.

23. During the man's previous time in custody at Gloucester, he had been quite disruptive and was identified as at risk of harming himself. An Assessment, Care in Custody and Teamwork (ACCT) self-harm observation and support plan was started. This was closed once it was assessed that the man no longer posed a risk to himself. On his return to Gloucester, he appeared to be much more settled and co-operative. It was therefore decided not to open an ACCT plan.

24. During his first reception health screening interviews, it was recorded that the man had history of alcohol dependency and an anxiety personality disorder. He was well known to the community mental health services who supported him both in the community and in prison. (Initial healthscreen interviews highlight any immediate mental or physical health problems requiring referral to the doctor or other specialist service.) On his return to custody, the man was prescribed quetiapine (an antipsychotic medication used to treat severe mental disorders) and was supported by both the Mental Health Inreach Team and the CARATS (Counselling, Assessment, Referral, Advice and Throughcare Scheme) team.[3]

25. The man was located on the second floor of A wing, the induction wing (also known as A3 landing), in a double cell with another prisoner who also spoke Polish.

26. During an interview with the investigator as part of this investigation, one of the officers said that initially when the man arrived in custody his behaviour could be "buoyant" but he quickly settled down. The officer also said that the man:

> "was always well-behaved… He's always polite and respectful and he always complies to the wing rules and regimes. He has never been a problem and he was no different the last time than the time before really."

27. On 10 June, the man had an assessment with his worker from the CARATS team. When interviewed as part of this investigation, The CARATS worker confirmed that when she met with the man was positive in his attitude towards dealing with his addictions. She stated that although she had had previous

[3] Organisations specialising in the treatment of substance abuse have drugs workers based in most prisons. CARATS workers run programmes and offer counselling and support to prisoners. Access to the CARATS service is voluntary, by application of a prisoner.

dealings with the man his involvement on this occasion was “two way”. The CARATS worker described the man as more “stable” than when he had previously been in custody. She described him during his previous times in custody as “joking and laughing around, upsetting other inmates” and on a “high”.

28. The CARATS worker said that when she last saw the man, on 4 July, he appeared happy. She recalled that arrangements were being made for him to go onto medication to help with his alcohol addiction and for his release from custody. She confirmed that her last interaction with the man had been a social conversation about Poland prior to her going on leave. She said that:

> “He was making sort of positive plans for release there was nothing to indicate that there was any distress or stress.”

The CARATS worker was on leave when the man died and she was informed of his death by telephone.

29. On 21 June, the man was seen by a Consultant Psychiatrist who recorded in his progress notes that he “appeared tense but not particularly depressed”. The psychiatrist decided that he would increase the dosage of the man’s quetiapine by 100 milligrams per day. He also recorded: “With regards to risk issues, there didn’t appear to any particular elevation in suicide or self-harm risk. His behaviour remains very settled with no particular suggestion of any increase of risk of harm to others at present”.

30. On 7 July, the man was sentenced to 20 weeks at Magistrates’ Court for harassment. He was due to be released from custody on 28 July due to the time he had already served on remand. The man was also barred by the court from entering the city of Gloucester unless he was collecting his medication.

31. When interviewed as part of this investigation, a member from the Mental Health Inreach Team confirmed she had supported the man whilst he had been in custody. She said that he had always been pleasant and had engaged with her when she had seen him. In relation to his final period in custody, she said:

> “This time his mood appeared generally more stable to be honest. There didn’t seem to be the aggressive edge to him that sometimes have been on previous times in custody and he actually appeared to be associating better with the other prisoners. In the previous times when he’s been in here he’s got into quite a few difficulties when it’s come to interacting with other prisoners.”

32. On 8 July, the member of the Mental Health Inreach Team saw the man following his court appearance. She asked him about his court appearance so that he could inform her about any concerns. The man wanted confirmation about the arrangements for his medication after his release. The member of the Mental Health Inreach Team said that he “very clearly” understood the restrictions in relation to him coming into Gloucester and how to avoid being recalled into custody. She took this as him understanding what had happened

at court. At interview, she also confirmed that no prisoners or staff raised any concerns about the man in relation to his mental health in the days leading up to his death.

33. On the following day, 9 July, the man's personal officer wrote in his record that the man was "a lot more settled and his behaviour has improved he now keeps himself to himself and conforms to all regimes".

34. At around 10.25am on 12 July, a member of the Offender Management Unit who facilitated counselling sessions for prisoners visited the man in his cell. In his statement to the Governor, he said that he invited the man to attend a session with his counsellor. He wrote that the man climbed off his bed, came to the door and replied: "No thanks, maybe next week. My belly is sick and I have a headache". He confirmed that the man presented in his normal polite manner and he did not give him any cause for concern. In his opinion "there was no indication of change to his normal polite self".

35. Later that same morning, at around 11.00am, an officer opened the observation hatch in door of the cell shared by the man and his cell mate. He asked them whether they wanted to go on exercise. The man was on the top bunk and pointed down to his cell mate who waved at the officer and said he wanted to go on exercise. The officer then unlocked the cell to let the cell mate leave and then moved onto the next cell. When he was interviewed, the cell mate told the investigator that the man had never gone out on exercise whilst they shared a cell therefore this was not considered unusual.

36. The officer returned to the man's cell, once he had completed that side of the landing, to lock the door. Another prisoner on the same landing was using the telephone and the officer waited until he finished his call before locking him back in his cell. He then returned to the wing office on the ground floor.

37. The man's cell mate returned from exercise around 12.15pm and when he arrived at his cell the door was already unlocked so he was able to go straight in. Following enquiries made by the Operations Manager it appears that an officer had unlocked the cell on the landing as per normal practice on A wing as prisoners return from exercise and collect their lunchtime meal. When interviewed as part of this investigation, no officer could not recall specifically opening the cell. However, an officer did admit that he did not routinely look through the observation hatch in a cell door before opening it.

38. An officer was assisting a domestic cleaner on the landing on A wing when he was approached by the cell mate. He beckoned the officer to come to this cell. When the officer pushed the door open it met with resistance, which was the locker with the television on top of it. This did not cause the officer much concern because the prisoners often watch television this way as it is difficult to view it when they are on their bed. The officer shouted into the cell asking the man to move the locker so he could enter the cell. He received no reply and by looking through the glass observation panel the officer could see that the cell toilet curtain was closed. He shouted again assuming that the man was in the toilet but again received no reply. The officer then tried to reach around the

door to move the locker but found this too difficult to do. He then saw the man on the left hand side of the cell in a kneeling position suspended by a ligature around his neck, in the form of bed sheet, tied to the bar on the cell window. When interviewed as part of this investigation, the man's cell mate said that when he tried to move the television so that he could enter the cell he saw the man at the back of the cell suspended by a ligature. This is when he asked staff for assistance.

39. The officer gestured to a colleague to assist him. The officers then moved the locker to one side and entered the cell. Whilst one officer cut the ligature from the bars and then from the man's neck, the other officer left the cell to ask another colleague to use his radio to summon assistance. A code blue response was called (a radio code which is used to indicate an emergency where someone is not breathing). The man was lowered to the floor to check for a pulse and any signs of life. A nurse and the Head of Healthcare at Gloucester arrived at the cell within a couple of minutes. An officer left the cell and went to get the defibrillator[4].

40. Another officer assisted the healthcare care staff in their attempts to revive the man. When they received the defibrillator the healthcare staff attached the defibrillator to the man, which after its first assessment said to continue with cardio pulmonary resuscitation (CPR)[5]. On its second assessment, the defibrillator advised for a shock to be administered. This was carried out and CPR continued. The healthcare staff were joined shortly afterwards by the prison doctor. When the paramedics arrived, at around 12.30pm, they took over the man's care. However, the attempts to resuscitate him were unsuccessful and the man was pronounced dead at 12.49pm.

41. After the man's death, the prison activated its death in custody contingency plan. As is common practice whenever there is a death in custody, the police visited Gloucester and interviewed staff. They found no suspicious circumstances.

42. After the man died, Gloucester appointed a Senior Officer as the prison's family liaison officer. He informed the family of the man's death and maintained contact with the family. Gloucester also offered financial assistance with the costs of the man's funeral. The family visited Gloucester on 22 July and spent some time in the man's cell. The man's funeral took place on 3 August 2011. The prison's family liaison officer also made arrangements for all of the man's belongings to be returned to his family following the funeral.

43. The prisoners were informed of the man's death during the afternoon of 12 July. They were also asked whether they required any support or wanted to

[4] A defibrillator measures electrical activity in the heart and issues audible instructions about treating the patient including, when appropriate, delivery of an electric shock.

[5] CPR, or cardio-pulmonary resuscitation, is a combination of rescue breaths and chest compressions to keep blood and oxygen circulating in the body.

speak to a Listener. All the prisoners who were subject to self-harm and suicide monitoring were reviewed.

44. Staff were shocked that the man apparently hung himself as there had been no warning signs. When interviewed as part of this investigation, one of the officers informed the investigator that the man had been teaching him how to count in Polish. He had seen the man during the morning of 12 July and had said good morning in Polish to him and he responded. The officer said that the man was smiling and “there was nothing out of the ordinary, he seemed okay“.

45. After a death, prison managers must hold a “hot debrief”. This is a meeting of all the staff who were involved in finding and attempting to resuscitate the prisoner. The meeting should focus on reassurance, information sharing and how staff can support each other. A hot debrief was held on 12 July. There were no areas of concern raised at that time and the staff who had been on duty were offered support from the prison’s care team.

ISSUES

Medical care

46. As mentioned earlier in this report, when the man returned to custody in May 2011 he appeared to be more proactive in his attempts to deal with his alcohol problems. He fully engaged with the CARATS and Mental Health Inreach teams. Staff from both the CARATS team and Mental Health Inreach Team, commented on his positive involvement with them during his final time in custody.

47. As previously noted, a review of the man's medical care was undertaken by a doctor on behalf of Gloucestershire Primary Care Trust. From the medical records, it was clear that the man was seen regularly by healthcare staff and, when necessary, referred to secondary care services. In his review, the clinical reviewer says that:

> "It is perhaps ironic that during periods of incarceration, with alcohol unavailable and a "fixed abode", mental health teams were able to assess the man more fully and develop a sustainable relationship. In view of this, I conclude that the man's care within HMP Gloucester was at least as good as would have been expected of a patient in the community and probably better than he would have received."

The emergency response

48. The man was discovered hanging by an officer after his cell mate raised the alarm. Within a few minutes of this discovery the officer had radioed for and received assistance, an ambulance had been called, the man had been cut down from his hanging position. The paramedics arrived 15 minutes after the initial call for help. Attempts were made to resuscitate the man but these were unsuccessful and death was pronounced at 12.49pm.

49. From both the paperwork provided and the investigator's interviews with staff, we are satisfied that all those involved acted quickly and in a professional and considerate manner.

50. The clinical reviewer commented in his clinical review that:

> "A fully and proper resuscitation attempt was made… Calling a halt to the resuscitation attempt after 45 minutes was appropriate, as brain damage by that time would have been irreversible."

Assessment, Care in Custody and Teamwork

51. The ACCT suicide and self-harm monitoring arrangements were put in place during the man's previous time in the custody of HMP Gloucester. The ACCT was closed within a few days and the appropriate post-closure reviews took place. It is our opinion that the ACCT procedure was used effectively, within a

multi-disciplinary setting, with sensible levels of observations and conversations and reasoned assessments regarding reviews and closure.

52. Following this the man gave no cause for concern regarding risk of self-harm or suicide on his return to custody. All those who knew him, prisoners and staff included, were shocked and surprised that he apparently took his own life.

53. The clinical reviewer concludes:

> "Having read the notes carefully and interviewed staff I would agree that there was no indication that the man would take his own life. I also conclude that the man's care by mental health teams at HMP Gloucester was exemplary. He appeared to have good rapport with mental health workers, who in turn visited him regularly and assessed his mental state."

The discovery of the man

54. When the man's cell was unlocked to allow his cellmate access to the cell, the officer did not look inside and check on the man's wellbeing. We understand that it may not be practical for staff to check prisoners for signs of life whenever they unlock a cell. We also realise that it is common practice across a portion of the prison estate to unlock cells to accommodate easy movement of prisoners when they return from exercise. However, this meant an earlier opportunity to find the man was missed. We recognise that, in this case, it may not have changed the outcome as it was only seconds between the man's cell mate entering the cell and the alarm being raised.

55. From interviews with staff at Gloucester it is clear that there is an understanding that when a cell is unlocked in the morning, and after the prison has been in patrol state[6], that staff should check on the wellbeing of prisoners. The purpose of this check is to confirm that the prisoner has not escaped, is ill or has died. This practice is not continued throughout the day apparently due to the practicalities involved in managing a prison with the limited resources that are available. Although there is no evidence that this would have made any difference to the tragic outcome in the man's case, this does expose a weakness in safety and, indeed, security arrangements.

56. The investigator discussed this issue in detail with the former Governor and Deputy Governor at Gloucester who agreed that there should be a review of the unlocking procedures at Gloucester. We, therefore, recommend:

The Governor of HMP Gloucester should ensure that checks are carried out on prisoners whenever a cell door is unlocked.

[6] This is when prisoners are locked up and staff numbers are reduced to the minimum needed to patrol. The main role of staff at this time is to maintain the security of the prison.

CONCLUSION

57. On 13 May 2011, the man was remanded into the custody of HMP Gloucester. It was discovered, during the afternoon of 12 July 2011, that the man had used a ligature to take his own life. He was cut down and attempts to resuscitate were carried out by staff at the prison and paramedics. Unfortunately, these proved unsuccessful and by 12:49pm it was confirmed that the man had died.

58. The clinical reviewer concludes:

> ”Having read the notes carefully and interviewed staff I would agree that there was no indication that the man would take his own life… the man’s care within HMP Gloucester was at least as good as would have been expected of a patient in the community and probably better than he would have received.”

59. We agree with the view of the clinical reviewer that the standard of the man’s medical care whilst he was at Gloucester was equivalent to that which he would have expected to receive in the community.

60. We make only one recommendation regarding the need for staff to make better checks on prisoners when they are unlocked, although there is no evidence that these would have altered the outcome in the man’s case.

RECOMMENDATION

At the draft report stage, the National Offender Management Service (NOMS) responded to the recommendation. That response is included in italics below the recommendation.

1. The Governor of HMP Gloucester should ensure that checks are carried out on prisoners whenever a cell door is unlocked.

   Accepted - A local Governor's information Notice will be issued outlining the need for all staff when opening/unlocking a cell to use the observation glass to check on the prisoner/s. Head of Residence to include on morning briefing, comment in wing observation/handover books.