

**Investigation into the circumstances surrounding the
death of a prisoner at HMP Brixton
in February 2008**

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

July 2009

This is the report of an investigation into the circumstances of the sudden death of a prisoner at HMP Brixton. The man was found collapsed in his cell on A wing at 8.30am. Sadly, efforts to resuscitate him by prison staff and paramedics failed and he was pronounced dead shortly afterwards. He was 53 years old. I offer my condolences to all those who knew him and were affected by his death.

My colleague conducted the investigation on my behalf. I thank the Governor of Brixton and his staff for their cooperation with the investigation. I am particularly grateful to staff who provided excellent liaison with my office. In addition, an independent review into the man's medical care was undertaken by Lambeth Primary Care Trust. I am also very grateful to them for their valuable contribution.

The man gave his next of kin as a friend whom he had met in prison and who now lives in the community. One of my family liaison officers spoke with friend, a former prisoner whom he befriended, and I am most grateful to him for giving my investigator access to the man's private papers.

I make three recommendations. The first relates to ensuring that clinical notes in manuscript are also entered on the main computerised clinical records. The other recommendations are about staff adhering to policies and procedures regarding those prisoners who refuse food, and about retaining information relevant to my investigation.

I must apologise for the delay in issuing this report. The clinical review was not received until the end of 2008.

The prison service have accepted my recommendations and their response is documented on page 18 of my report.

Stephen Shaw CBE
Prisons and Probation Ombudsman

July 2009

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SUMMARY

In 1995, the man received a 14 year prison sentence. Having served three quarters of this sentence, he was released on licence to live at Approved Premises. He was recalled to prison in December 2006 for failing to keep to the conditions of his licence.

The man did not have contact with his family. He gave his next of kin as a friend whom he had met in prison.

His reception interview with healthcare staff was held two days after his recall to prison. At that interview, he said he had an appointment to attend hospital for a magnetic resonance imaging (MRI) scan in January 2007. (MRI is a medical imaging technique to produce detailed images of the body.) This was to investigate a spinal problem which made mobility difficult. It was also noted that he had been diagnosed with depression and angina, and he was prescribed painkillers and antidepressants. To assist his mobility, the man was located on the ground floor of A1 wing at Brixton.

Throughout his time at Brixton, the man made a number of complaints about getting his medication in a timely manner. The prison investigated these matters and he was permitted to have a month's supply of his medication in his own possession in his cell.

It is not clear whether the man attended for the MRI scan in January 2007. Manuscript records suggest that he did, but there is no entry on the EMIS computerised clinical record to confirm this. I have made a recommendation regarding the importance of keeping the computerised system up to date as this is the main point of access to information for staff.

The man was assaulted in early November 2007. There is little information about this assault in the clinical record, or what action was taken, only that he received blows to the chest. It is significant because the clinical reviewer is of the opinion that this was the point at which the man's health deteriorated. A note of complaint to staff regarding the assault, handwritten by the man, was found in the papers given to my investigator by the man's friend. There is no evidence that this note came to the attention of staff as, when asked by my investigator, neither discipline nor medical staff appeared to know about it. The investigation was complicated by the absence of wing history sheets which my investigator was told had been 'disposed of'. I have made a recommendation in this regard.

After the assault, the man was thought to have tuberculosis (TB). However, hospital tests proved this was not the case. The man remained very unwell. He was admitted to King's College Hospital in December 2007 as an emergency, as one of the prison doctors had raised concerns that he might be suffering from a lung abscess. The man was discharged in late December, having been diagnosed and treated for a cavitating pneumonia.

The last entry in the clinical record was made on 27 January 2008, a week and a half before the man's death. It says that he did not attend surgery. However, there is no

evidence of any action taken by healthcare staff in response. The man's wing history sheet might have assisted with this information and its absence is regrettable.

On 7 February 2008 at around 8.25am, Officer A was called to the man's cell by his cellmate who said that the man was not breathing. The officer called for assistance. Officer B put out a code 1 emergency medical assistance call over the radio net. Healthcare and discipline staff responded bringing oxygen and the defibrillator machine. A Governor asked a Principal Officer to call an ambulance. With the assistance of discipline staff, healthcare staff placed the man on the floor to give them extra space in the cramped and poorly lit conditions of the cell. Healthcare staff took it in turns to carry out cardio pulmonary resuscitation (CPR) on the man. A Senior Healthcare Officer took charge of the resuscitation and defibrillator procedures. A prison doctor, arrived and assisted staff until the London Ambulance Service arrived.

Sadly, the man did not respond to the resuscitation attempts and he was pronounced dead by the doctor and the paramedics at 8.45am. He was 53 years old.

My investigation has concluded that all staff responded rapidly to the man's collapse. I agree with the clinical reviewer that a high level of competency was shown by officers and healthcare staff in their attempts to resuscitate the man. However, the Governor will wish to consider three recommendations. Two relate to record keeping, specifically that manual and electronic clinical records should correspond, and that records of deceased prisoners should be retained by the prison while there is an ongoing investigation by my office. The third relates to staff awareness of policies and procedures regarding prisoners who refuse food.

While I am aware that there are questions that remain unanswered regarding the assault on the man, I judge that the medical care he received before his collapse and subsequently was appropriate.

INVESTIGATION PROCESS

1. I was notified of the man's death on 8 February 2008. Terms of Reference and notices were issued to staff and prisoners at Brixton telling them that an investigation would be taking place, and inviting those who wished to see the investigator to make themselves known. My investigator requested copies of the man's core record, clinical record and other records relevant to his time in custody and his death.
2. My investigator also contacted HM Coroner. The purpose was to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. The report concludes that the man died of:
 - 1a Pulmonary Oedema
 - 1b Coronary Artery Disease
 - 2 Chronic Obstructive Pulmonary Disease.
3. Lambeth Primary Care Trust (PCT) were commissioned to provide a clinical review. The review, which appears as an annex to this report. I received the review on 31 December 2008.
4. My investigator visited the prison informally on two occasions and met the Head of the Secretariat, the Head of Healthcare, other healthcare and wing staff, and a prisoner who knew the man. The clinical reviewer and my investigator jointly visited A wing and were shown the man's cell, the wing office and wing facilities. Formal interviews with staff were conducted jointly with the clinical reviewer. After these interviews, the clinical reviewer and the investigator met with the Governing Governor.
5. The Head of the Secretariat acted as the prison's liaison officer. He told my investigator that the man did not have any family who had made themselves known following his death. A friend who knew the man while in prison was unaware that he had named him as his next of kin. The man's friend told one of my family liaison officers that he was surprised to have been named but was pleased to assist the investigation. He also told her that he was not contacted by the prison and did not understand what was expected of him as the man's nominated next of kin.
6. During the course of the investigation, the investigator consulted previous investigation reports relating to the deaths of prisoners at Brixton. None of the recommendations in those reports has been repeated in this one. She also read reports on Brixton by HM Chief Inspector of Prisons, Dame Anne Owers, and by the prison's Independent Monitoring Board (IMB).

HMP BRIXTON

7. HMP Brixton is a cramped, Victorian, local prison, serving a number of courts in South London. It holds both sentenced and remand prisoners with a high daily turnover.
8. The prison's population rarely falls below its operating capacity of 798. My investigator was told that the average length of stay for a prisoner is around eight weeks, although the man had been located at Brixton since his recall in December 2006.
9. There are four main residential units. A wing, where the man was located, is the largest wing with an operating capacity of 264. The wing is used to house the prison's workforce and those attending education classes. D wing is a 25 bed inpatient unit, for prisoners with mental health needs and those requiring medical observation.
10. At the time of my investigation, Brixton's healthcare provision was on the eve of change. A new contract for healthcare services was to begin the day after my investigator first visited. My investigator was told that healthcare would be offered by a consortium led by Care UK, with Lambeth Primary Care Trust as the main provider. In their 2007/2008 report, the prison's Independent Monitoring Board says that there have been positive changes within healthcare at Brixton, and that a good relationship has been forged between the Head of Healthcare and the IMB.
11. In her report of an unannounced short inspection in May 2008, Dame Anne Owers, HM Chief Inspector of Prisons, acknowledged the difficulties Brixton faced in respect of limited resources and a challenging population with diverse needs. My investigator found that the complaints the man had made regarding healthcare were appropriately addressed. Dame Anne's report concluded that the complaints system operated in healthcare was 'adequate'.

KEY FINDINGS

12. On 24 August 1995, at the Central Criminal Court, the man received a 14 year sentence. This was not his first prison sentence and he was familiar with the prison regime. He continued to proclaim his innocence of his offences and therefore did not engage in any of the offending behaviour courses designed to lower his risk of re-offending and work towards a successful return to living in the community.
13. The man was released on licence under the supervision of the Probation Service three-quarters of the way through the custodial part of his sentence in March 2004. On release, he was required to live at Approved Premises. However, his behaviour on licence was poor, resulting in a recall to prison on 15 December 2006.
14. It is unclear why there is an Induction Portfolio document dated 4 September 2007 suggesting that the man was received into the prison as a new reception prisoner on that date. In interview, staff confirmed that he entered the prison in December 2006 and there is no documentary evidence to the contrary. In addition, my investigator was unable to access wing history sheets which were not kept with the core record. They were not within the bundle of papers sent to my investigator at the outset of the investigation, nor were they offered to her when she visited the prison. When she asked for the wing history sheets, the prison's liaison officer told her that he had enquired of the wing and had been told that they had been disposed of.
15. Throughout his time at Brixton, the man appeared dissatisfied with the medical services provided to him. My investigator has had sight of a number of formal complaints he made to the prison, both personally and through his solicitor. They focussed on his difficulties obtaining an appointment to see the doctor, and receiving pain relief medication for his spinal problem in a timely manner. The prison appears to have investigated these complaints and responded appropriately, taking action where necessary.
16. The man's clinical record shows that he was assessed by a doctor in a reception interview on 18 December 2006, the day after his recall to prison. At that interview, it was noted that he had an appointment to attend St George's Hospital for a magnetic resonance imaging (MRI) scan in January 2007. It was also recorded that the man had angina and severe back problems which led to difficulties in walking and sitting. He revealed that he had been treated for depression in 1976. Prior to imprisonment, he had been prescribed diclofenac sodium tablets (an anti-inflammatory drug), co-codamol (prescribed for pain relief), and amitriptyline hydrochloride (an antidepressant). Advice to stop smoking was also given to him and it was recorded that he did not wish to do so. Despite his health and mobility problems, on 19 December he was assessed as fit for 'normal location, work and any cell occupancy'.
17. A review of the man's medication was held on 17 January 2007. At that review, he appears to have complained of 'ongoing leg pains'. He was given a repeat

prescription and permitted to have a week's supply of medication in his possession in his cell.

18. From the start of his time at Brixton, the man's clinical records mainly chart a history of complaints about not receiving his medication. On 16 October 2007, a prison doctor recorded that the man remained unhappy that his medication had not been made available as he required. The doctor decided that the man should receive his medication in possession monthly. (This means that he was allowed to retain the medication in his cell.)
19. My investigator found two pages of handwritten clinical notes within the papers sent to her. The signatures to the entries are illegible, with the exception of the final entry dated 9 January 2008 when the man failed to attend the doctor's surgery (the reason is not recorded). It is not clear why a handwritten method of recording is in place when the computerised system is the primary means of recording clinical information and is effective. Entries on the handwritten clinical notes are not always recorded on the computerised system, and important information could go unnoticed as a result. For example, within the handwritten notes is an entry dated 4 September 2007 confirming that the man attended for his MRI scan on 24 January 2007. My investigator could find no evidence in the computerised clinical record that he attended this scan.
20. On 4 November 2007, a nurse made an entry in the clinical record saying that she attended the man's cell at 1.30am. She said that he complained of dizziness and sickness and revealed to her that he had been 'on hunger strike since Friday'. My investigator examined the Food Refusal Book held on A wing but there was no reference to him. Other healthcare and wing staff, interviewed both formally and informally, were not aware that the man had been on a hunger strike. The next entry, dated 7 November and made by a doctor, does not acknowledge anything relating to this event, but details that the man had been attacked by another prisoner and had suffered injury. In the absence of evidence to the contrary, I assume that information relating to the man's alleged 'hunger strike' was not passed on to staff and the reasons for his action also remain unknown.
21. On 29 November, a doctor recorded that the man had been unwell since his assault and was producing brown sputum. A chest x-ray was arranged and, on 3 December, the handwritten clinical notes by an unknown individual recorded, "the man is seen by the GP ASAP with his x-ray."
22. Medical staff at Brixton considered that the man could be suffering from tuberculosis (TB) and a referral was made to King's College Hospital, London. This proved not to be the case, but the doctor raised his concerns regarding a possible lung abscess in the clinical record entry dated early December and in a referral letter on the same day to colleagues at King's College Hospital. The man was admitted as an emergency to the hospital's Accident and Emergency Department.
23. During the man's stay in hospital, healthcare staff at Brixton frequently communicated with the hospital to enquire as to his diagnosis and likely

discharge date, and to monitor his progress. The clinical record shows that communication was sometimes difficult as hospital staff were not forthcoming with information. In late December, the man was discharged from hospital, having been treated for a cavitating pneumonia.

24. The man remained very unwell on discharge from hospital and was located on the ground floor of his prison wing. A note on both the EMIS computerised clinical record and a handwritten note by healthcare records that the man failed to attend the doctor's surgery on 10 January 2008. The EMIS system shows that he did not attend the surgery because he could not walk. The man was not seen by medical staff until 13 January when the following was recorded: "poor exercise tolerance prior to pneumonia and worse since. He is complaining of right lung pains and clear phlegm, the pain is not as bad as December." He was said to need a wheelchair "if going off wing" due to "breathing difficulties". The doctor wrote a letter the same day to a Consultant Physician, raising concerns that the man did not have a hospital discharge review and asking for a review "soon". An entry in the clinical record dated 14 January confirmed the letter had been marked as "urgent".
25. A series of tests were carried out and, on 24 January, a doctor at Brixton recorded that there had been a recurrence of the man's chest pain. He was re-admitted to King's College Accident and Emergency Department and discharged the same day with a salbutamol inhaler to assist his breathing. There was no sign of "active pneumonia".
26. The clinical record says that the man was seen by a doctor at the prison in late January. During that appointment, the man complained of "lower central chest pain ... pleuritic and stabbing ... radiating to L arm". The doctor noted that the man found the nitrolingual spray (for angina) to be of benefit. The clinical reviewer is unclear where the man got the spray as there is nothing in the clinical record to suggest that he had active angina symptoms.
27. It appears from an entry in the clinical records that 27 January 2008 was the last time the man was seen by medical staff. On 29 January, it was recorded that the man did not attend surgery. There is no evidence that staff took any action either to visit him on the wing or ensure that the doctor did so. The man's missing wing history record might have provided this information.

Events on 7 January 2008

28. In interview, Officer A said he arrived on duty on A1 landing at around 8.25am. He remembered walking down the landing towards the staff room where he intended to put his bag. He recalled that, as he was passing down the landing, he heard "someone bang on his cell door and shout 'Gov'." Looking down the landing he said he saw "the A1-29 cell bell light was on and shouting coming from that area." Officer A told my investigator that he was aware that the man was not a well man. He recalled that, as long as he had known him, the man had had breathing difficulties and walked with two crutches.

29. Officer A unlocked the cell and the man's cell mate told him that he thought the man was "having trouble breathing". He asked the cell mate to step out of the cell and, seeing the man lying on the bottom bunk, he sent him the 10 or 15 feet across the corridor to the treatment room to fetch a Nurse A. (He told my investigator he did this because it was quicker than waiting for medical help from a call over the radio net.) He also called Officer C who was close by. Officer A said both he and Officer C tried to find the man's pulse without success.
30. In his statement, Officer C said that, when he heard Officer A call him, he was standing around ten feet away from cell A1-29 talking to a prisoner from the kitchen working party. On arriving at the cell, he recalled Officer A checking for a pulse in the man's neck but not finding one. He said he tried to find a pulse in the man's wrist but also could not find one. I consider Officer C showed presence of mind by removing a mirror from the wall, holding it over the man's mouth and nose to see if he was breathing.
31. At this time, Officer B was returning to the landing from the staff room. He saw Officer A open the man's cell door and was alerted by his cell mate. Officer B went to the cell and shouted to staff to send a code 1 call over the radio net. (A code 1 call tells staff that there is a life threatening situation. Code 2 is serious but not life threatening. A code 3 call is a minor incident that might not necessarily need medical attention but needs to be recorded.) The note of the hot debrief following the man's death says that Officer B made the code 1 call over the net. This was followed by a second call by a Principal Officer.
32. In his statement, the principal officer said that at 8.27am he heard a call for assistance from cell A1-29. When he arrived at the cell, he saw Officers A and C trying to find a pulse on the man. He said that Nurse 1 arrived "within seconds". At the time the man was discovered, Nurse 1 was in the treatment room near to his cell. Statements record that she started cardio pulmonary resuscitation (CPR). The principal officer said that a Governor arrived and instructed him to call an ambulance. The Governor said in her statement that she arrived at the cell at 8.30am.
33. A Senior Officer (SO) was the senior officer in charge of A wing on 7 February. He said that at 8.27am he had just left the daily morning briefing meeting when he heard a code 1 for A wing. He arrived at the man's cell and saw Officers C and A checking the man for signs of a pulse. He confirmed that Nurse 1 was there and that she had given the man oxygen and started CPR.
34. A Senior Healthcare Officer (SHO) said at around 8.30am he was in the main healthcare administration unit when he heard the code 1 called over the radio net. He attended immediately and saw a member of staff carrying out CPR. He told my investigator that he very quickly assessed the situation and realised that staff would be unable to work effectively on the man while he was lying on the bottom bunk bed. The SHO said he instructed staff to move the man to the floor. This was done with the help of the SO and Officers A and C. The SHO said that CPR continued until the defibrillator arrived with another member of healthcare staff. As the resuscitation and CPR instructor for the prison, the SHO said he took the lead in directing staff to take turns in giving CPR. He said the space

they had to work in within the man's cell was very restricted and made matters much more difficult. After unpacking the defibrillator, he attached it to the man and also inserted an OP airway. (An OP airway is a piece of equipment that opens up the airway by keeping the tongue in place during artificial ventilation of a patient.) All staff left the cell except the medical staff and Officer C (who found it difficult to get out from the back of the cell because of the restricted space).

35. Having attached the defibrillator to the man, the SHO said that an electric shock was advised. This was given and CPR continued. At 8.41am a prison doctor arrived at the cell and assisted staff with their efforts to resuscitate the man. The SHO said that the doctor examined the man but could not find a pulse. He was not breathing and his pupils were fixed and dilated. The doctor pronounced the man's death at 8.45am.
36. At 8.42am, the London Ambulance Service arrived at the prison and reached the wing at 8.45am. They conducted an examination of the man using an electrocardiogram (ECG) and confirmed that the man had died.
37. A hot debrief for staff was held later that day at 2.00pm. It was attended by the majority of the staff involved. Staff felt that they had managed matters well and, from the information provided, I agree. The debrief confirmed that the Staff Welfare Team were there to assist staff. In addition, all those prisoners on an open Assessment, Care in Custody and Teamwork document (ACCT) had been reviewed. (ACCT is a monitoring process intended to support those who are feeling vulnerable or at risk of self-harm or suicide while in prison.)
38. The incident log shows that at 8.53am all staff had left the cell and it was secured with a second lock. The police arrived and the cell was re-opened by the principal officer. All staff involved in the response to the man's collapse were present at this time. After the police had completed their procedures, the man's body was collected by the Funeral Directors. The cell was re-secured.

ISSUES

Clinical care

39. The clinical review was undertaken by Lambeth Primary Care Trust. Together with my investigator, the clinical reviewer conducted interviews with medical staff and officers at Brixton. In his clinical review, he says that he was, "impressed with the level of care provided by the medical and other healthcare staff for the man, particularly since the assault of 7 November 2007, and the appearance and recurrence of the chest infections." The clinical reviewer adds, "This level of care certainly seems commensurate with a good standard of care which might be received by somebody in the wider community outside the prison environment."
40. The clinical review does not make specific recommendations but highlights the matter of the man's assault. There is little mention of this within the documents received by my investigator other than an entry in the clinical record for 7 November 2007. The clinical reviewer is of the view that the assault appears to have coincided with the man's marked deterioration in health. He describes the lack of information regarding this incident as "disconcerting" and I agree. Interviews with staff revealed that they had been unaware of the assault. It might be the case that the assault and any action taken by the prison was documented in the man's wing history sheet but, as noted earlier, they have been disposed of by the prison. The man's handwritten note of complaint regarding the incident cites medical negligence, failure of a duty of care by the prison, and asserts that he asked for police involvement following his injury. This is undoubtedly of real concern. However, as the note was contained within the man's private papers, I cannot assume that staff received it. Had it reached prison staff, it should manifestly have merited investigation by the prison. The fact that the note was found with other private papers handed to my investigator by his next of kin raises questions that can no longer be answered with any certainty.

Response by staff on 7 February 2008

41. The clinical reviewer has highlighted areas of good practice during the response to the man's collapse by both prison and healthcare staff. He notes their professionalism in managing the man's care and treatment. In particular, he is impressed by the speedy response to the code 1 call when the man was found. The clinical reviewer considers the response both rapid and well organised: "in technical terms [it] appears to have been highly competent in all respects."

Record keeping

The EMIS computerised system of clinical record keeping is used by the prison. Generally, entries are clear and informative. However, my investigation found that handwritten records are used alongside this at times, and the manuscript entries do not always correspond with those on the EMIS system. An example of this was when the man's attendance for an MRI scan on 24 January was recorded on the handwritten clinical record but not on the computerised EMIS system. The information was not vital in this case but could prove to be so in the future.

If the EMIS system of recording is to be used alongside handwritten clinical notes, the Head of Healthcare should inform staff that information from the handwritten notes should be entered on the EMIS system.

42. My investigator found that neither wing nor healthcare staff were aware that the man had been deliberately refusing food. Within the clinical record, mention is made of the man being on 'hunger strike'. There is no evidence that healthcare staff passed this information to wing staff either verbally or by recording it in the Food Refusal Book. As food refusal is a form of self-harm, the expectation is that an ACCT document should be opened. No action appears to have been taken by healthcare staff who made subsequent entries in the clinical record, and did not take note of the previous entry of 4 November regarding food refusal.

The Governor and Head of Healthcare should make staff aware of their obligation to adhere to policies and procedures regarding prisoners who refuse food.

43. At the outset of the investigation, my investigator asked for all relevant records regarding the man's time in custody to be sent to her. She did not receive the wing history sheets. When my investigator asked for them during the latter part of the investigation, she was told that they had been "disposed of". PSO 2710 paragraph 6.5 asks requires the prison to "draw together the documents (which will be found in a variety of locations) that the investigating teams will need as soon after the death as possible to minimise any allegations of interference." Paragraph 1.3 of the joint working protocol between the Prisons and Probation Ombudsman, NOMS and the Prison Service regarding death in custody investigations asks that "all staff co-operate fully with all requests from the Ombudsman or his/her staff for information, material or access to establishments." As Brixton has experienced a number of deaths since 2004 which have been investigated by my office, it is reasonable to expect the prison to have a good knowledge of the documents required. All documents relating to the prisoner who has died should be set aside in the expectation they will be required for my investigation and not disposed of until the investigation has been completed.

The Governor should ensure that all relevant files and documents relating to deceased prisoners are preserved and not disposed of by the prison prior to the inquest or the conclusion of my investigation.

Conclusion

44. Despite his poor health, the man's death was sudden and unexpected. The swift and highly competent response of discipline and healthcare staff, and by London Ambulance Service paramedics, was not enough to save his life. I commend the efforts of all staff involved.
45. A question will remain as to how far the assault upon the man served as a contributing factor to the decline in his health.

46. This investigation has drawn attention to the importance of ensuring that information regarding significant events such as assaults and food refusal is recorded, shared and acted upon appropriately. I have made recommendations relating to this issue and the retention of prisoner records until the conclusion of the investigation and inquest.
47. Those matters aside, the investigation found the quality of medical care the man received was reasonable and equivalent to that which he would have received in the community.

RECOMMENDATIONS

If the EMIS system of recording is to be used alongside handwritten clinical notes, the Head of Healthcare should inform staff that the information from the handwritten notes should be entered on the EMIS system.

Accepted. The primary recording system for medical information by all healthcare staff in all areas of the prison including D wing.

The Governor and Head of Healthcare should make staff aware of their obligation to adhere to policies and procedures regarding prisoners who refuse food.

Accepted. A Staff Information Notice will be distributed reminding staff of the policy in relation to food refusal.

The Governor should ensure that all relevant files and documents relating to deceased prisoners are preserved and not disposed of by the prison prior to the inquest or the conclusion of my investigation.

Accepted. The Death in Custody checklists for Duty Governors, Family Liaison Pack and local policy all detail the requirements in relation to paperwork in the event of a Death in Custody.