PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at HMP Whitemoor in September 2012

Our Vision

‘To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision’

This is the report of an investigation into the death of a man in September 2012 at HMP Whitemoor. He was found hanging in his cell. He was 49 years old. I offer my condolences to his family and friends.

The investigation was carried out by two investigators. A clinical reviewer reviewed the clinical care the man received at Whitemoor.

The man had been at Whitemoor since May 2012. His mental health was assessed three times by the mental health professionals but they all concluded that there were no signs or symptoms of mental disorder. He was not considered to be at risk of suicide and gave no signs that he was likely to harm himself.

One morning in September, after cells were unlocked, another prisoner went to the man's cell and found him hanging by a belt around his neck which was attached to the window. Officers cut the belt and tried to resuscitate him. Paramedics arrived and took over the resuscitation attempt but, sadly, this was unsuccessful.

We agree with the clinical reviewer that the man was appropriately assessed by mental health services at Whitemoor, and his suicide was not foreseeable or preventable. The emergency response was swift and every effort was made to revive him. However, we consider that officers should be required to check on the wellbeing of prisoners when unlocking cells, although we cannot know whether, had he been found earlier, the outcome would have been any different.

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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **June 2013**

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SUMMARY

1. The man was remanded into custody on 7 January 2011 and initially taken to HMP Brixton. In November 2011, he received a life sentence and transferred to HMP Whitemoor on 18 May 2012. He said that he had previously suffered a stroke and had been diagnosed with depression, but was not currently on medication. He had a history of alcohol misuse.

2. In the months before the man's death, some concern was raised about erratic behaviour. However, he had three separate assessments by mental health staff at Whitemoor and all concluded that he did not have a mental illness and was not suicidal.

3. One morning in September, officers carried out a roll check and unlocked the man's wing, but they did not speak to him. We have made a recommendation about this. At 8.44am, a prisoner was worried that he had not seen him, so went to his cell and alerted officers that he was hanging. An officer radioed the emergency. Healthcare responded and an ambulance was requested. Officers started cardiopulmonary resuscitation (CPR), before the nurses arrived and took over. The prison doctor attended the scene and agreed CPR should continue. Paramedics arrived on the wing at 9.06am. Resuscitation attempts were unsuccessful and he was pronounced dead at 9.13am.

4. Because of the distance involved, the prison asked Sussex Police to break the news of his death to his family. Subsequently, no representative of the prison visited them personally, as required by national guidance. We have recommended improvement in family liaison arrangements after a death in custody.

5. In light of the clinical reviewer's findings, we are satisfied that the clinical care the man received at Whitemoor was comparable to that which he could have expected in the community. His death was not preventable.

THE INVESTIGATION PROCESS

1. The Ombudsman's office was notified of the man's death on 13 September 2012. The investigator issued notices to staff and prisoners informing them of the investigation and asking anyone with relevant information to contact him. He interviewed one prisoner as a result.

2. The local PCT appointed a clinical reviewer to review the man's clinical care. He was given a copy of the man's medical record.

3. The investigator visited Whitemoor on 18 September 2012, when he was given the man's documentation. He met the Governor and other senior staff, including representatives of the Independent Monitoring Board (IMB).

4. The investigator and clinical reviewer returned to Whitemoor on 8 and 11 October to interview staff and prisoners. Another investigator subsequently completed the investigation. She returned to Whitemoor on 11 January, and interviewed four additional members of staff and re-interviewed an officer in light of new evidence. She conducted three telephone interviews on 16 January. Both investigators fed back to the Governor during the course of the investigation.

5. HM Coroner for North and East Cambridgeshire District was informed of the investigation. A copy of the report has been sent to the Coroner.

6. One of the Ombudsman's family liaison officers contacted the man's sister to explain the purpose of the investigation. She asked that the investigation consider:

   - What medication was prescribed to her brother and for what reason?
   - Why was he allowed to have a belt in his possession?
   - What contact he had with the chaplaincy?
   - Whether the news of his death was broken appropriately?

7. The man's family received a copy of the draft report as part of the consultation period. His sister asked a number of additional questions about her brother's time at Whitemoor, medication, contact with mental health professionals and assessments made during the time he was in custody. Although the comments have led to no changes in the investigation report, the investigator has addressed the issues raised in separate correspondence to the family.

HMP WHITEMOOR

8. HMP Whitemoor is part of the High Security Estate. It holds over 400 category A and B prisoners serving four years or more. Healthcare provision is the responsibility of NHS Cambridgeshire. NHS Cambridgeshire commissions general practitioners and nurses to provide prison primary medical services. Cambridgeshire and Peterborough NHS Foundation Trust manage the prison's mental health provision.

HM Inspectorate of Prisons (HMIP)

9. HMIP's last inspection of Whitemoor was in January 2011. The Inspectorate considered that healthcare was reasonably good, but primary mental health services were too limited to meet the needs of the population. HMIP found excellent joint working between health care and other prison departments.

10. HMIP found that Whitemoor was safer that at a previous inspection in 2008, and that prisoners at risk of suicide and self-harm were well cared for. Prisoners told inspectors that they felt safer at Whitemoor than they had in the past. Inspectors found that mental health input into suicide prevention procedures was inconsistent and support plans for those at risk of suicide or self-harm were not always good quality.

Independent Monitoring Board (IMB)

11. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that proper standards of care and decency are maintained. The most recently published IMB annual report for Whitemoor covers the year to May 2011. The IMB agreed with the Inspectorate that the capacity of the mental health team was inadequate to meet the needs of prisoners at Whitemoor.

Previous deaths at Whitemoor

12. The man's death was the first death at Whitemoor since March 2008.

KEY EVENTS

HMP Brixton

13. The man attended court charged with murder on 7 January 2011. It was noted on his Person Escort Record (PER) that he had attempted to jump off a bridge three years earlier and escort staff completed a suicide and self-harm form because of this and the nature of the charge. He was remanded into custody at HMP Brixton, but staff at reception did not assess him as at risk of self-harm.

HMP Belmarsh

14. The man transferred to HMP Belmarsh on 17 October. A prison psychiatrist assessed him on 4 November, and prescribed diazepam *(*a drug used to reduce anxiety*)* to help him cope with his trial. He was convicted of murder and, on 14 November 2011, was given a life sentence with a minimum of 13 years and 54 days to serve.

15. In early 2012, officers made several positive entries in the man's record about his work as a wing cleaner and his efforts on the Toe by Toe (literacy) programme to improve his reading skills.

16. On 15 May 2012, a Senior Officer referred the man for a mental health assessment. A Community Psychiatric Nurse (CPN) assessed him on 17 May. He told her that he had suffered from depression in the past and had been prescribed antidepressants by his GP for six months, but had decided to stop taking them. She documented that his mood was subdued, but he had no thoughts of self-harm. She arranged for an appointment with a psychiatrist on 12 June, but he transferred to Whitemoor before the appointment took place.

HMP Whitemoor

17. The man was moved to HMP Whitemoor on 18 May 2012. He arrived at the prison after 5.00pm on a Friday so the rest of the prison was locked up. This meant that he had only a brief introductory meeting with healthcare staff to cover essential first night information. He told a nurse he was prescribed thiamine (a vitamin), vitamin B, dipyridamole (to treat high blood pressure) and simvastatin (to treat high cholesterol). He said that he had been treated for depression in the past but did not feel like he might self-harm. There is no record that they discussed his mental health assessment the week before, or the outstanding psychiatric appointment. He was given a cell on C wing (the induction wing).

18. The man reported the same information about his medication and history of depression to a nurse the next day. She referred him to the mental health team because he had a history of depression and was anxious about being at Whitemoor. She told the investigator that she had a good conversation with

him about his alcohol use and relationship breakdown. She did not consider him at risk of suicide.

19. The man spoke to someone from the prison's chaplaincy team on 20 May, as part of his induction. He was put on the church list, although he never attended a service.

20. On 21 May, a doctor reviewed and continued the man's prescriptions (dipyridamole and simvastatin). The doctor told the investigator that he was not concerned about the man's physical or mental health. The doctor said that he did not have any signs of depression or warrant a mental health assessment.

21. Two days later, the man saw a nurse, who reviewed his medical history. He repeated that he had no thoughts of self-harm. He recounted his alcohol misuse, and the nurse wrote in his clinical record that he considered that being in prison had given him a personality disorder. He said his memory had been badly affected by the stroke he had suffered before he went to prison and he could not always ask for help because he found it difficult to remember people's names. The nurse recommended that he try occupational therapy.

22. An officer made a negative behaviour entry in the man's record on 24 May, because he used aggressive language during his offender management induction. Another negative entry was made two days later when he argued with the search team about his property.

23. On 30 May 2012, an officer introduced himself as the man's personal officer (a named officer who is the first point of contact). He discussed his conduct with him, and he agreed that he needed to moderate his behaviour. He said that he had difficulty reading and writing, so the officer gave him the names of the Toe by Toe representatives on the wing (prisoners who support other prisoners learning to read and write).

24. A nurse (Belmarsh) noted in the medical record on 30 May, that the man had been transferred to Whitemoor before an appointment with a psychiatrist could take place. The nurse recorded that Whitemoor's mental health services would consider his mental health needs before deciding whether he needed to be referred for a psychiatric assessment.

25. The man moved to a residential wing on 30 May, after completing his induction. On 10 June, an officer introduced himself as his relief personal officer (for when his personal officer was not on duty).

26. The man's sister told the investigator that she contacted the chaplaincy department at Whitemoor as she was concerned about her brother. The Roman Catholic chaplain confirmed that she visited the man on 31 May in response to his sister's concerns. She told the investigator that he was annoyed that she had visited, but that she had no reason to be concerned about his safety.

27. A nurse from the mental health team saw the man on 14 June, after a nurse's referral at reception. The nurse recorded that he was "settled and calm, made reasonable eye contact and adopted a generally relaxed body posture", but dismissed some of the nurse's questions. He said that he was a bit flat because he was in prison, but the nurse noted that he had no signs of depression. He said he did not have any formal thought disorders (such as hallucinations or delusional beliefs). The nurse noted that he said that he felt controlled by the system, but the nurse was unsure if this reflected the unfamiliar high security setting of Whitemoor or was indicative of paranoia. The nurse referred him to a consultant forensic psychiatrist for a review of his mental state. Although the nurse said he was almost certain that he was not paranoid, he explained to the investigator that he wanted a psychiatrist to assess him to be sure.

28. The man received a written warning on 19 June for refusing to go to his cleaning course in the afternoon. He argued about the course registration he was asked to sign, but was persuaded to remain on the course.

29. The man was assessed by psychiatrist on 22 June, who described him as generally polite and relaxed. The psychiatrist explained to the investigator that he was not particularly happy to discuss his mental health because he did not think he needed mental health support. He said he only wanted support to cope with memory loss which he believed was caused by his stroke. The psychiatrist suggested that he follow this up with the primary care team. He diagnosed no mental disorder and told the investigator that the man had no symptoms of depression.

30. On 1 July, the man's new personal officer described him in his case notes as a very isolated person who spent a lot of time in his cell. He told the officer that he had no problems and he was happy by himself. The officer told the investigator that he did talk to other prisoners and he never worried that he was being bullied.

31. Another officer on the wing said that he knew the man reasonably well and he never had any concerns that he was bullied or isolated. Another prisoner told the investigator that he and the man spent some time with each other and often cooked together. He said that the man had some friends on the wing and was not bullied.

32. The psychiatrist wrote to the man on 10 July to confirm that he did not need secondary mental health treatment. He suggested that he speak to the GP if he had any more concerns about his mental health and wellbeing.

33. On 11 July, the man objected to a task in education with an instructor, which he claimed was testing his memory. On 13 July, he reacted aggressively to another instructor for what was said to be no apparent reason. A security incident report was completed about both incidents, and the security manager suggested that he should be removed from education if he continued to be aggressive towards his tutors. The next day, his personal officer wrote that he had spoken to him about the two negative entries in his case notes, and he

assured the officer that nothing was wrong. The officer noted that he had started to spend time with Muslim prisoners, rather than by himself, and thought that he was trying to fit in more.

34. On 17 July, an instructor recorded that, although the man had completed his cleaning course, he could not receive the certificate to become a cleaner because he had refused to sign his registration form.

35. On 27 July, the man went to an education class. The tutor wrote in his case notes after the class that he had refused to write a list of words because he thought he was being analysed. She recorded that he was frustrated that he was not being taught to write, but she reflected that he would not participate in her attempt to teach him. He threatened to leave the class, but quickly changed his manner to "chatting and laughing" and stayed in the class until the end.

36. The man's offender supervisor referred him for a mental health assessment on 2 August because of his erratic behaviour during education. He was due to be assessed by a clinical psychologist on 8 August, but he refused to participate. The psychologist noted that the mental health in-reach team would discuss at their next meeting if any further work with him was required.

37. On 10 August, the man was sent back to the wing from education as he had been rude to the teacher. During his sentence planning review board, he continually argued with the board chair (his offender supervisor) who responded by explaining what was expected of him in terms of behaviour during his prison sentence.

38. On 5 September, the man refused to talk to a representative from the psychology department who was trying to discuss the best way to support him with his education. He said he was unwilling to complete any education assessments. She emailed his offender supervisor two days later to suggest that he needed to have the benefits of an educational assessment explained.

39. The psychologist assessed the man on 6 September. He was irritated because he had not asked to see the psychologist and that he was being assessed because other people found his behaviour difficult. The psychologist recorded that he was not depressed, although he agreed that he had become more withdrawn since being at Whitemoor. He was frustrated that he had to do literacy and numeracy work before he would be considered for offending behaviour programmes and felt that he was constantly being scrutinised without his permission. Again, the psychologist concluded that he had no mental illness, and the mental health in-reach team could offer him no support because he was not willing to engage and had no mental illness.

40. On 12 September, the man was involved in what was called a play-fight with another prisoner during an education class. The tutor who ran the class said that he had got on well with the prisoners in the class until that day. The tutor said that the fight was friendly to start with, but got more serious, until he

called an officer in to stop the fight in case someone got hurt. He wrote in a security incident report:

> "Less than a minute later a prisoner told the man he would not be very happy with an entry or IEP warning. He became louder and threatened him saying: 'If I get an entry I will get you next time in education.' I called officers to have the prisoner removed."

41. The tutor said that he specifically explained that he would not give either of the men an IEP warning, but would do if it happened again. He explained to the investigator that he asked for the prisoner to be removed from the classroom because he had threatened the man. He said that the man appeared unconcerned by what had happened.

42. After the man's death, Officer A was asked to investigate the altercation to determine if he was being bullied, or it had any bearing on his death. The officer interviewed the prisoner, who said that he knew him from Belmarsh where they got on reasonably well. He explained that the man was aware that he had given evidence leading to the conviction of his co-defendant and called him a "snitch". He said that this had not been a problem at Belmarsh, as it was said in good humour. However, he told the officer it had become more of a problem at Whitemoor. He was worried that other prisoners would hear it and make trouble for him. He said he asked him to stop, but he continued.

43. The prisoner told the officer that he and the man were pushing each other in the education department because he continued to call him a snitch. The officer told the investigator that the prisoner never used the phrase "play-fight" and indicated that the disagreement was genuine, but not serious. The officer said that the prisoner admitted to the altercation but denied threatening him. He told her that he asked him to leave him alone, but he had never threatened him.

44. The evening before the man's death, his friend explained that they planned what to buy for their meals that week (as they often cooked together). He was concerned about them having enough food and tobacco but his friend assured him that they still had plenty of food in the freezer. The man's personal officer told the investigator that he locked him in his cell for the night. He said that he was sitting on his bed clipping his toe nails and had said good night in a normal manner. The officer said that there was nothing to suggest that he would harm himself.

45. The investigator reviewed the man's telephone calls in the weeks leading up to his death. Although he expressed some frustration with elements of the prison system (such as healthcare), his telephone calls did not feature any long-standing or significant concerns. He gave no indication that he was thinking about suicide or harming himself.

Events of the incident

46. In September, Officer B did a morning roll check at about 7.30am. He looked into each cell to count the prisoner, and noticed nothing of concern. Officer C started to unlock the wing at about 8.00am. Officer C opened the flap to each cell door before he unlocked the door and moved to the next cell. He did not open the door, go into the cell or speak to the prisoners. CCTV showed him arriving at the man's cell at 8.03am, opening the flap and unlocking the door before moving to the next cell.

47. The man's friend said that he had stayed in bed watching television after his cell had been unlocked. He said that the man would normally come to his cell, but he noticed it was later than usual and thought he had overslept. He wanted to make sure they submitted their food order that morning, so went to check on him.

48. Officer B initially claimed to have seen the man on the landing dressed in his tracksuit at about 8.30am. During the interview for this investigation, he said that he could no longer be sure that it was him he had seen on the landing. The investigator reviewed the CCTV footage and he did not leave his cell at any point after the cells were unlocked at 8.03am. No-one entered his cell until he was found hanging.

49. When the man's friend got to his cell the door was unlocked but pulled shut. He looked in and could not see him, so he wondered if he was having a shower or collecting his medication. He said he was about to leave when he saw him behind the curtain at the back of the cell, and thought he was hiding as a joke. He shouted, but got no response, so he pulled the curtain back and realised he was hanging. He tried to lift him up but he was too heavy, so he ran out of the cell to get help. CCTV showed that he left the cell at 8.44am and spoke to an officer on the landing above. Officer B left the wing office when he heard shouting and went downstairs. He did not realise the seriousness of the situation until he got to the cell, when the man's friend told him that he was hanging by a belt from the window frame.

50. Officer B cut the man down using his anti-ligature knife and laid him on his back in the middle of the cell. He said that he was warm, but there was some mottling on his face and thighs. The officer could not be sure whether rigor mortis had set in, but he had no problem moving him to the floor.

51. Officer D was told what had happened by another prisoner and arrived to help. A general emergency alarm was called at 8.45am. Officer E arrived and began rescue breaths while Officer D did chest compressions. Another officer arrived and took over chest compressions from Officer D. Officer C had also responded to the emergency alarm and, realising the urgency of the situation, he returned to the centre office and asked an officer to call a code blue alarm (used for medical emergencies related to breathing). Two members of healthcare staff heard the emergency code and went to the wing.

52. A SO requested an ambulance at 8.48am. An OSG (officer support grade) in the control room called for an ambulance at 8.49am. A Healthcare Officer (HCA) arrived at 8.50am and took over CPR from Officer E. Another officer brought a defibrillator (a portable electronic device that detects activity in the heart and advises whether an electric shock is appropriate to re-start the heart) and an oxygen bag. The HCA attached the defibrillator to the man but no shock was advised. A nurse arrived and supplied oxygen to him through the oxygen bag. A doctor was telephoned and arrived on the wing at 8.56am. He told the investigator that he assessed him and found no signs of life. After checking that the ambulance was on its way, he agreed that CPR should continue.

53. The ambulance arrived at the gate at 8.55am followed by a second ambulance at 9.07am. The paramedics undertook a series of checks using an ECG machine (electrocardiogram which measures activity in the heart) but the doctor, with the agreement of the paramedics, pronounced the man dead at 9.13am.

Support for prisoners

54. A note from the Governor was posted under prisoners' doors on the wing informing them of the man's death. Notices were posted elsewhere in the prison. All prisoners subject to suicide prevention measures were reviewed in case they had been affected by the death. Prisoners were reminded of the support available from the Samaritans and the Listeners.

Liaison with the man's family

55. When he arrived in prison, the man nominated his sister as next of kin. A custodial manager was appointed to be the prison family liaison officer (FLO). Because of the distance, Sussex Police were asked to inform the man's sister of his death on the prison's behalf. Initially the police had difficulties in establishing contact with her, but at 1.30pm they informed her son and provided contact details for the prison family liaison officer. At 2.50pm, she contacted the FLO, who explained to her what had happened and what support was available from the prison. Although the FLO maintained contact with her, no personal visit was arranged as required by Prison Service Instruction (PSI) 64/2011 Safer Custody.

Support for staff

56. The care team (staff trained to support each other following an incident) were present on the wing to talk to any staff who required immediate support. A hot debrief was held by the Deputy Governor, to discuss the incident and reassure staff involved.

ISSUES

Risk of suicide

57. A suicide and self-harm warning form was opened by the escort staff when the man appeared in court charged with murder. Staff at Brixton noted that he had tried to jump off a bridge three years earlier but did not consider him to be at significant risk of harming himself at the time and concluded that he did not need to be monitored for suicide or self-harm.

58. Officers at Whitemoor made regular entries in the man's case history notes, and described him as private and not willing to speak about personal matters. His behaviour was described as erratic and staff referred him to the mental health team accordingly, but there was never any indication that he was intending to harm himself. His family asked why he was allowed to keep a belt in his possession. Prisoners are ordinarily allowed to keep such items in their cells and officers do not remove possessions from prisoners unless there is a specific reason. As he was not judged to be at risk of suicide or self-harm there was no reason to suspect he would use his belt, or any other item to end his life. The clinical reviewer concluded:

> "This review has not found any evidence that the man had suicidal intent or that his death could have been prevented."

59. We agree with the clinical reviewer that staff at Whitemoor could not reasonably have foreseen the man's death.

Clinical care

60. Mental health professionals assessed the man on three occasions at Whitemoor. A mental health nurse assessed him after his reception and referred him to a psychiatrist. Neither thought he needed support from the mental health team. After education staff expressed concern about his erratic behaviour, a clinical psychologist assessed him, and again found that he did not need the support of the mental health team.

61. The clinical reviewer is concerned that the man was encouraged by a member of the mental health team to talk to the primary care team or his GP about other health issues, but there is no record of independent communication between the primary care and mental health teams. However, overall, the clinical reviewer concludes that his access to mental health professionals was greater than he could have expected in the community and his primary care was equivalent.

The man's contact with staff and prisoners

62. Staff and prisoners told the investigator that the man got on well with other prisoners and was not a victim of intimidation or bullying. They described him as someone comfortable in his own company with a small group of acquaintances.

63. The man and the prisoner had an altercation the day before his death. The prisoner is alleged to have threatened him (although he denies it). The teacher warned both prisoners that they risked incurring an IEP warning for continued bad behaviour. It does not appear that it was a serious confrontation, or that the man felt troubled by the incident. Initially the teacher thought they were play-fighting. The prisoner was not on the same wing as the man, even if he had felt threatened by him. The man's friend told the investigator that the man did not appear concerned by the event at all and joked about it that evening. There is no evidence that the altercation with the prisoner was relevant to his later actions.

64. The prisoner told Officer A that he considered that the man had changed since they had been together at Belmarsh, to the extent that he wondered if he was on medication or had a mental health condition. He said he could not understand why he continued taunting him when he told him repeatedly that it bothered him.

Unlock procedures

65. Officer B started the morning roll check at 7.29am. The CCTV shows him looking into the man's cell and no concerns about his welfare were recorded at this time. At 8.02am Officer C started unlocking cells and got to the man's cell at 8.03am. The CCTV shows that he had a cursory glance into the cell before he moved on. CCTV confirmed that the man did not leave his cell after that. At 8.44am the man's friend went to his cell and alerted staff that he was hanging.

66. Officer C told the investigator that he did not think he was required to get a response from prisoners when he unlocked their cells. He said he looked through the observation panel on the cell door to "safeguard myself for health and safety and make sure nobody's going to push the door back at me". In fact, he remembered that he could not have seen into the cell that morning because it was pitch black. None of the officers we asked during the investigation considered that it is necessary to get a response from prisoners during morning unlock.

67. Officers are told in their initial training that they should check the safety of prisoners when they unlock cells. Prison Service Instruction (PSI) 10/2011, paragraph 2.3 also clarifies the responsibility of the unlocking officer:

> "Where prisoners are not necessarily expected to leave their cell, staff will need to check on their well-being, for example by obtaining a response during the unlock process."

68. Because Officer C did not seek a positive response from the man when unlocking his cell, he was found by another prisoner who raised the alarm. While it might not have prevented his death, on unlocking cells, staff should get a response in line with their training.

The Governor should ensure that when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.

Informing the man's family of his death

69. Sussex Police informed the man's family of his death. PSI 64/2011 says that when a prison representative has not broken the news in person, a follow-up visit with the prisoner's next of kin must be arranged as soon as possible. In this case, because of the distance, the decision to ask the police to break the news on the prison's behalf was reasonable, but should have been followed up by a visit from prison representatives.

The Governor of should ensure that family liaison officers arrange to visit a prisoner's next of kin as soon as possible after a death in custody.

RECOMMENDATIONS

1. The Governor should ensure that when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.

   Accepted - A Staff Information Notice has already been published reminding staff of their responsibility to obtain a response from prisoners to check on their safety on unlocking, as per PSI 10/2011. Supervising Officers in all residential areas will be responsible for ensuring this procedure is adhered to and will also brief staff accordingly. Target date: March 2013 – Completed.

2. The Governor should ensure that family liaison officers arrange to visit a prisoner's next of kin as soon as possible after a death in custody.

   Accepted: The establishment FLOs have been made aware of this requirement and it will be annotated in the establishment policy for handling a death in custody and also into the local contingency plan. Target date: June 2013.