Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Steven Batty a prisoner at HMP Lincoln on 21 June 2016

A report by the Prisons and Probation Ombudsman
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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Steven Batty was found hanging in his cell at HMP Lincoln on 22 June 2016, just a few hours after arriving, and was pronounced dead in hospital shortly afterwards. He was 47 years old. I offer my condolences to Mr Batty's family and friends.

Mr Batty expressed suicidal thoughts from his arrest through to his reception at Lincoln. The severity of his risk was recorded on various documents that accompanied him to prison, but was not effectively considered once he arrived at the prison. It is particularly disappointing to find that the prison failed to make proper use of an innovative early risk identification and alert scheme they have funded. Sadly, Mr Batty's death, within hours of his arrival at Lincoln, might have been prevented had a more co-ordinated approach been taken to managing his risk.

This is the second of two deaths at HMP Lincoln in 2016 where my investigation found that the prison had failed to follow Prison Service suicide and self-harm procedures. They follow earlier deaths where I raised similar concerns. My recommendations to address identified failings have routinely been accepted, but substantive action and learning has not been evident. In the circumstances, I look to the Deputy Director of Custody to assure herself that Lincoln can provide a safe environment for prisoners at risk of suicide and self-harm, and report her findings to my office.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **November 2017**

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Summary

Events

1. On 19 June, Mr Steven Batty was convicted of criminal damage and assault following an altercation at his estranged wife's home. When he was arrested, he held a pitchfork against his abdomen and said he wanted to kill himself. He told the police he would kill himself once he was released and a healthcare professional who assessed him at the police station noted he might have bipolar disorder. At court on 21 June, an officer completed a suicide and self-harm warning form and staff checked Mr Batty six times an hour while he was in the court cells.

2. Mr Batty was remanded to HMP Lincoln and a court caseworker assessed his immediate needs before he was taken to the prison. He told her he had last tried to harm himself two days before and was having suicidal thoughts. He said he had depression and had been prescribed medication. He also told her he had attempted suicide before. The caseworker spoke to a prison mental health nurse who considered that Mr Batty needed a routine mental health assessment. The caseworker recorded details of Mr Batty's risk of suicide and self-harm on a 'keep safe' form, which accompanied him to prison. Details of his risk were also recorded on other forms which arrived with him.

3. After he arrived at Lincoln, a nurse began Prison Service suicide and self-harm prevention procedures (known as ACCT). Although Mr Batty's raised risk of suicide had now become evident, it is not clear whether he was referred for an urgent mental health assessment.

4. A prison manager considered the actions staff needed to take to keep Mr Batty safe in his first hours at the prison. However, she did not read any of the documents which arrived with Mr Batty. She decided, on the basis of what he said to her and how he appeared, that staff should check him once an hour at irregular intervals. She did not consider him to be at a high risk of suicide or self-harm.

5. At about 5.45pm, Mr Batty was given a single cell on the First Night Centre. Staff checked Mr Batty four times between then and 7.20pm and recorded no concerns. At 8.01pm, an officer checked Mr Batty and found him suspended from the washbasin taps with a ligature around his neck. The officer raised the alarm and staff responded quickly, removed the ligature and began cardiopulmonary resuscitation. Paramedics arrived at 8.07pm and, at 8.52pm, took Mr Batty to the local hospital. He did not regain consciousness and was pronounced dead at 9.12pm.

Findings

6. We have serious concerns about how staff at Lincoln responded to the clear risk information about Mr Batty that was gathered by the police, the court caseworker and court escort staff and which accompanied him to prison. There was a wealth of information indicating that Mr Batty was at a high risk of suicide but staff did not give this the weight it deserved. Instead, they relied on Mr Batty's

presentation and demeanour. Although staff began ACCT procedures, they did not accurately assess Mr Batty's level of risk and consequently, they did not take sufficient steps to safeguard him in his first hours at the prison. There is a troubling history of Lincoln failing to learn from repeated recommendations we have made to address these concerns.

7. It is disappointing that Lincoln is failing to make appropriate use of the innovative scheme they have set up to gather vital information about new prisoners.

8. We agree with HM Chief Inspector of Prisons who reported that the First Night Centre at Lincoln offered a bleak and isolating experience, particularly for a newly arrived prisoner who had never been in custody before.

Recommendations

- The Governor should produce clear local guidance about procedures for identifying newly arrived prisoners at risk of suicide and self-harm. In particular, this should ensure that staff:
    - Have a clear understanding of responsibilities and the need to share all relevant information about risk.
    - Consider and record all the known risk factors of a newly arrived prisoner when determining their risk of suicide or self-harm including information from the SPARC 'keep safe' form, suicide and self-harm warning forms and PERs.
    - Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.

- The Deputy Director of Custody for the East Midlands should ensure that Lincoln has effectively implemented all PPO recommendations made following self-inflicted deaths at the prison since 2012, assure herself that Lincoln can provide a safe environment for prisoners and provide a report to the Ombudsman outlining progress within three months of receiving this report.

- The Head of Healthcare should ensure that:
    - there is a clear mental health referral process
    - mental health referrals for prisoners assessed as at risk of suicide and self-harm are prioritised and carried out promptly
    - all healthcare are aware of the process for escalating a routine mental health referral to urgent
    - the referral form is retained in the prisoner's clinical record

- The Governor should ensure that the First Night Centre meets the needs of newly received prisoners and offers a clean, welcoming and supportive environment.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Lincoln informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

10. The investigator obtained a copy of Mr Batty's prison and medical records on 30 June.

11. NHS England commissioned a clinical reviewer to review Mr Batty's clinical care at the prison.

12. The investigator interviewed 14 members of staff between July and September 2016. The clinical reviewer joined the investigator for seven of the interviews.

13. We informed HM Coroner for Central Lincolnshire of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

14. One of the Ombudsman's family liaison officers contacted Mr Batty's mother and wife to explain the investigation process and to ask if they had any matters they wanted the investigation to consider. His family wanted to know what had happened to Mr Batty and why.

15. The initial report was shared with HM Prison and Probation Service (HMPPS) and Mr Batty's family. HMPPS did not find any factual inaccuracies and their action plan is annexed to this report. His family did not identify any factual inaccuracies.

Background Information

HMP Lincoln

16. HMP Lincoln holds more than 700 remand and convicted men. It serves the courts of Lincolnshire, Nottinghamshire and East Yorkshire. It has four residential wings including a vulnerable prisoners unit. Nottinghamshire Healthcare NHS Trust provides health services and there is 24-hour healthcare cover. Mental health care is provided on weekdays between 8.00am and 5.00pm with no cover at weekends.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Lincoln was in February 2017. Inspectors noted there was innovative work to identify the needs of new prisoners while they were still at court and alert prison reception to prisoners with special care, support or risk needs. They reported that in some cases, the prison's response to previous death in custody investigations as well as case management processes for prisoners at risk of suicide or self-harm was disappointing. Relationships between escort and reception staff were good and reception staff made appropriate use of information to inform initial risk assessments but significant delays created potential risks for prisoners on their first night.

18. Inspectors noted that conditions in the First Night Centre were poor, with dirty cells and a lack of additional checks on all new prisoners. They reported that new prisoners were often locked in their cells for the night without adequate support from staff or peer workers.

19. The inspection commented that two large mental health teams provided a range of services for primary and secondary care and that all uniformed staff had received mental health awareness training.

Independent Monitoring Board

20. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 31 January 2016, the IMB reported that the high level of self-harm incidents remained a concern. Reception staff frequently reported delays in admitting new prisoners because nurses were not available to assess their health needs.

Previous deaths at HMP Lincoln

21. Mr Batty's death was the fifth self-inflicted death at Lincoln since 2013. We investigated the self-inflicted death of another prisoner at Lincoln who died two weeks before Mr Batty. In both cases, we had concerns about how reception staff used risk information gathered at court. In 2013 and 2015, we made recommendations that reception staff should use all available information to inform their initial risk assessments. HM Inspectorate of Prisons most recent inspection noted that the prison's oversight of recommendations made in previous investigations needed improvement as there was no overarching plan to monitor their implementation.

Assessment, Care in Custody and Teamwork - ACCT

22. ACCT is the Prison Service care planning procedure used to support prisoners at risk of suicide and self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.

23. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

24. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

25. On 19 June 2016, Mr Steven Batty was arrested at his estranged wife's home after an altercation. When the police arrived, they found him holding a pitchfork to his abdomen, saying he would kill himself. He was arrested and charged with criminal damage and assault. The next day, while in police custody, Mr Batty told a healthcare professional that he intended to kill himself once released. The healthcare professional wrote that Mr Batty might have bipolar disorder, and that he must not be released from court without mental health support as his history and behaviour suggested a high possibility of self-harm.

26. Mr Batty remained in police custody until 21 June, when he appeared at court. During the day, a court custody officer completed a suicide and self-harm warning form, noting that Mr Batty had told the police that he would kill himself if he was released, but that he now said he felt okay as he had taken his (unspecified) medication. While at court, staff checked him six times an hour.

27. Mr Batty's Person Escort Record (PER - which accompanies prisoners on all journeys between police stations, courts and prisons, to communicate risk factors) had "states he will harm/kill himself when released from custody" handwritten on the front of the document in capital letters and highlighted by two asterisks. The risk indicator page of the PER noted that Mr Batty had attempted suicide 12 years earlier and had placed a pitchfork against his stomach at the scene of his arrest two days previously.

28. Mr Batty was remanded to HMP Lincoln until 12 July. He told a practitioner with Support for Prisoners After Remand or Conviction (SPARC - an organisation funded by the prison to highlight the immediate needs of prisoners while they are still at court) that he had never been to prison before. He said he had depression and anxiety, was prescribed antidepressants and had a prescription for more medication in his belongings. He told the SPARC practitioner that the healthcare professional in police custody had suggested that he might be suffering from bipolar disorder.

29. Mr Batty wanted to make arrangements to collect his belongings from his rented home and was anxious about his housing arrangements. He gave the SPARC practitioner the contact details for his mother and his adult son. He said that although there was a Restraining Order in place until 20 August, preventing him from contacting his wife, and although they were currently living apart, he was hopeful of a reconciliation.

30. The SPARC practitioner phoned Lincoln's healthcare team and spoke to Nurse A, a mental health nurse, to arrange for Mr Batty to have a mental health assessment when he arrived. The SPARC practitioner told the investigator that the nurse did not ask her whether Mr Batty was at risk of suicide or self-harm, but she told him that Mr Batty was thinking about killing himself. She said that she also tried to phone the prison's reception unit but there was no answer.

31. Nurse A said that the SPARC practitioner told him it was Mr Batty's first time in prison, that he had a history of anxiety and depression, was prescribed citalopram (an antidepressant) and that he needed to be assessed for bipolar disorder. He said that the SPARC practitioner did not mention that Mr Batty was

feeling suicidal, so he referred Mr Batty for a routine rather than urgent mental health assessment.

32. The SPARC practitioner phoned Mr Batty's mother to tell her Mr Batty had been remanded to Lincoln. His mother said she was worried he would kill himself and the SPARC practitioner tried to reassure her that he would be supported in prison. She also phoned Mr Batty's son and discussed the handover of his property. Both Mr Batty's mother and son asked the SPARC practitioner to pass on messages of support to Mr Batty. When she did so, Mr Batty seemed overwhelmed and said that he was having thoughts of suicide. The SPARC practitioner phoned Lincoln's reception unit again and told a member of staff (whose name she did not record), that Mr Batty had suspected bipolar disorder and thoughts of suicide. She completed a SPARC 'keep safe' form which is designed to allow the prison to put initial safeguarding measures in place, if necessary.

33. Mr Batty arrived at Lincoln at 2.20pm, with the SPARC 'keep safe' form and the PER. Officers A and B explained the reception and induction process to him. Mr Batty named his son as his next of kin and provided his contact details. He said he hoped to get back with his wife.

34. At about 3.00pm, a pharmacy technician handed Nurse A a note that Mr Batty was having suicidal thoughts. The nurse said this was the first time he had heard that Mr Batty might be suicidal. He alerted Nurse B, who was responsible for assessing the general health needs of new prisoners that day. Nurse B asked whether Nurse A planned to urgently assess Mr Batty's mental health. Nurse A replied that Nurse C was responsible for urgent mental health assessments that day. Nurse A said he would try to find Nurse C, but in the meantime suggested that Nurse B begin Prison Service suicide and self-harm monitoring procedures (known as ACCT) for Mr Batty.

35. Nurse A phoned several residential units in the prison looking for Nurse C but was unable to find her. He said that he did not try to radio her.

36. At 3.30pm, Nurse B assessed Mr Batty. He did not see the PER as reception officers at Lincoln do not routinely share PERs with reception healthcare staff, and could not recall seeing the SPARC 'keep safe' form. Mr Batty said it was his first time in prison, that he had a history of depression and anxiety, had recently tried to harm himself and was having suicidal thoughts. Mr Batty said that in the past he had taken overdoses, tied ligatures around his neck and attempted to cut himself, and most recently had tried to drive a pitchfork into his body, but it was too blunt.

37. Nurse B assessed that Mr Batty was at risk of suicide or self-harm and began ACCT procedures. He wrote in the ACCT plan that Mr Batty had said he would definitely kill himself if he could not resolve issues with his wife and he was having continuous thoughts of suicide and self-harm. Nurse B handed the ACCT plan to an officer and left the reception area at 4.10pm. Nurse B said he did not try to contact Nurse C about Mr Batty's mental health assessment as he had spoken with Nurse A and had begun ACCT procedures. He did not refer Mr Batty to see the doctor about his antidepressant medication.

38. At 5.00pm, a prison manager met Mr Batty and Officer A to complete the next section of the ACCT plan. The manager told the investigator that before she met Mr Batty, she spoke to the reception officers who did not consider Mr Batty to be at high risk of suicide or self-harm. The manager did not read any of the risk documents which accompanied Mr Batty from court and did not speak to Nurse B. Mr Batty told the manager he had not harmed himself for a while and had no current thoughts of suicide or self-harm. He was talkative and she thought he seemed upbeat and focused on the future. She instructed staff to check him once an hour until his ACCT assessment interview.

39. Officer A told the investigator that when he had read the information accompanying Mr Batty, he had considered that he was at a very high risk of suicide and self-harm. However, once Mr Batty had spent some time in the reception area interacting with others, he thought his demeanour was more positive, although his mood seemed 'up and down'. He did not share his concerns with the manager.

40. At about 5.45pm, Officer B took Mr Batty to his single cell in the First Night Centre (which is in the basement of A Wing), next to a cell where a prisoner was being constantly observed by staff.

41. According to CCTV footage, at 6.11pm, an officer checked Mr Batty. At 6.14pm, Officer C checked him again and recorded in the ACCT plan that he was lying on his bed and appeared asleep. At 6.57pm, Officer C checked Mr Batty again and noted that he was writing a letter. He checked him again at 7.20pm and noted no concerns.

42. At about 7.30pm, Officer D took over ACCT checks on A Wing, including the First Night Centre. There were 13 prisoners subject to ACCT checks of which four, including Mr Batty, were in the first night centre.

43. At 8.01pm, Officer D checked Mr Batty and saw him partially suspended from a ligature made out of shoelaces which he had tied around the taps on the sink. Officer D was not carrying a radio, so shouted for staff assistance. Officer B was close by and he and Officer D went into Mr Batty's cell. Officer B cut the shoelaces and they laid Mr Batty on the floor. At 8.02pm, the officer constantly observing the prisoner in the cell next door radioed to alert staff that a prisoner was hanging. According to East Midlands Ambulance Service logs, the prison requested an ambulance at 8.04pm.

44. A nurse and a healthcare support worker were nearby when they heard the radio message. They grabbed an emergency bag and a defibrillator and went to Mr Batty's cell where Officer E had already begun cardiopulmonary resuscitation. The healthcare staff took over resuscitation until the paramedics arrived at 8.07pm. At 8.52pm, the paramedics took Mr Batty to hospital. He was pronounced dead in hospital at 9.12pm.

Contact with Mr Batty's family

45. At court on 21 June, Mr Batty gave the SPARC practitioner the contact details for his mother and adult son which she recorded on the SPARC 'keep safe' form. When he got to Lincoln, a reception officer updated Mr Batty's prison record with

his son's telephone number, but did not record whether his son was an adult or child. The Governor said that when Mr Batty died, staff did not want to contact Mr Batty's son until they had established his age. Instead, the Governor asked a prison family liaison officer (FLO) to visit Mr Batty's wife (whose address was on the court warrant). The prison did not use the information gathered by SPARC and recorded on the 'keep safe' form which would have allowed this process to run more effectively.

46. The FLO arrived at Mr Batty's wife's house at 11.50pm, accompanied by the police, but she was not at home. Mr Batty's wife contacted the police during the morning of 22 June and they told her of her husband's death. At 11.30am on 22 June, the FLO phoned Mr Batty's mother but she did not answer so he phoned Mr Batty's son at work, explained what had happened and offered condolences. The prison contributed to the cost of Mr Batty's funeral in line with national instructions.

Support for prisoners and staff

47. After Mr Batty's death, the Governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

48. The prison posted notices informing other prisoners of Mr Batty's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm in case they had been adversely affected by Mr Batty's death.

Post-mortem report

49. A post-mortem examination established the cause of Mr Batty's death as hanging. Toxicology tests revealed no illicit drugs or medication in his body.

Findings

Assessment and management of the risk of suicide and self-harm

50. Prison Service Instruction (PSI) 64/2011, which covers Safer Custody and PSI 07/2015, Early Days in Custody, lists a number of risk factors and potential triggers for suicide and self-harm. Mr Batty had several of these risk factors – he was in prison for the first time, he had been convicted of a violent offence against a family member, was subject to anti-harassment measures imposed by the police (although prison staff would not have known of this as his police custody record was not forwarded to Lincoln), had a history of attempted suicide and self-harm and had mental health problems. The level of Mr Batty's risk was recorded on the PER, the SPARC 'keep safe' form and the court suicide and self-harm warning form. Although we consider that one of the reception officers should have initiated ACCT procedures as soon as Mr Batty arrived, rather than Nurse B during his later assessment, we are satisfied that Mr Batty was correctly identified as being at risk of suicide and self-harm when he arrived at Lincoln.

51. However, we have very serious concerns about how prison staff assessed Mr Batty's level of risk. We are concerned that no one took overall responsibility for ensuring that Mr Batty's serious risk of suicide was noted and acted upon. We consider it inexcusable that the prison manager did not refer to any of the documentation accompanying Mr Batty when she assessed his immediate level of risk, set the frequency of staff checks and considered the initial actions staff should take to safeguard Mr Batty in his first hours at Lincoln. Instead, she relied on his presentation and demeanour during their conversation.

52. A prisoner's presentation can reveal something of their level of risk, but it is only one piece of evidence and is merely a reflection of their state of mind at the moment they are seen. While staff judgement is fundamental to the ACCT process, it must be informed by all available risk information and local and national policies, not merely their presentation.

53. A PPO Learning Lessons bulletin published in February 2016, identified that the most common theme among deaths in early days and weeks of custody was a failure to act on information about known risk factors. As noted earlier, another prisoner also took his life at Lincoln two weeks before Mr Batty. As in that investigation, we highlight that reception staff made insufficient use of risk information recorded on the SPARC 'keep safe' form. HM Inspectorate of Prison's most recent inspection report of Lincoln described SPARC as an excellent initiative. We agree that it provides good quality and valuable information about prisoners before they arrive at Lincoln. However, it is essential that all staff who are responsible for assessing risk of self-harm or suicide read all relevant information, including SPARC and PER forms. We have raised this issue with Lincoln before. We make the following recommendation:

The Governor should produce clear local guidance about procedures for identifying newly arrived prisoners at risk of suicide and self-harm. In particular, this should ensure that staff:

- **Have a clear understanding of responsibilities and the need to share all relevant information about risk.**

- **Consider and record all the known risk factors of a newly arrived prisoner when determining their risk of suicide or self-harm including information from the SPARC 'keep safe' form, suicide and self-harm warning forms and PERs.**
- **Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.**

54. We acknowledge that once Mr Batty had moved to the First Night Centre, staff there checked him at a greater frequency than the prison manager had instructed.

55. We are concerned by what appears to be a troubling history of Lincoln failing to learn from repeated recommendations we have made following investigations of deaths in custody. In light of this we make the following recommendation:

The Deputy Director of Custody for the East Midlands should ensure that Lincoln has effectively implemented all PPO recommendations made following self-inflicted deaths at the prison since 2012, assure herself that Lincoln can provide a safe environment for prisoners and provide a report to the Ombudsman outlining progress within three months of receiving this report.

Mental health assessment

56. The clinical reviewer concluded that the healthcare Mr Batty received was not equivalent to that he could have expected in the community as he did not receive an urgent mental health assessment when the resources were in the prison to do so.

57. The SPARC practitioner raised concerns about Mr Batty's mental health with Nurse A before Mr Batty arrived. At that point, Nurse A considered that a routine referral for a mental health assessment was sufficient. When he learnt that Mr Batty was feeling suicidal, he took limited steps to arrange for Nurse C to urgently assess him.

58. The mental health team work Mondays to Fridays from 9.00am – 5.00pm. We acknowledge that, had Nurse C been tasked to urgently assess Mr Batty, she might not have been able to do so that day, but we are concerned that healthcare staff were unclear about how to escalate an urgent mental health referral. We make the following recommendation:

The Head of Healthcare should ensure that:

- **there is a clear mental health referral process**
- **mental health referrals for prisoners assessed as at risk of suicide and self-harm are prioritised and carried out promptly**
- **all healthcare are aware of the process for escalating a routine mental health referral to urgent**
- **the referral form is retained in the prisoner's clinical record**

The First Night Centre

59. First night and induction procedures are intended to provide extra support for newly-arrived prisoners to identify and reduce the risk of suicide and self-harm. The early days of custody are often a daunting and difficult time for prisoners and a period of vulnerability for those at risk of suicide. First night centres should have a welcoming, interactive environment to try and put the prisoner at ease. Mr Batty had spoken to SPARC earlier in the day about his concerns for his belongings, housing and family relationships. The experience of imprisonment, especially for the first time, can magnify worries that prisoners have not been able to resolve before entering custody.

60. The First Night Centre at Lincoln offered a bleak and isolating experience to new prisoners. Staff told the investigator that a number of the cells in the First Night Centre were unusable due to disrepair, and had been in this condition for several weeks. The Centre was used to accommodate some prisoners who were not new and had been placed there for reasons that were unclear, and this also served to blur the focus of the unit. HM Inspectorate of Prisons' last inspection of 2013 characterised the First Night Centre as grim, grubby and not a suitable environment for the first night. We agree with their findings and are very disappointed that little progress appears to have been made to improve conditions.

61. In September 2016, the investigator emailed her concerns to the acting Governor, the Regional Estates Manager and a manager at Amey, the contractor responsible for maintaining the fabric of the prison. The Regional Estates Manager acknowledged that he was working with Amey to address the prison's needs. We make the following recommendation:

    The Governor should ensure that the First Night Centre meets the needs of newly received prisoners and offers a clean, welcoming and supportive environment.

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