Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mark Kinman a prisoner at HMP High Down on 17 October 2018

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T I 020 7633 4100
F I 020 7633 4141

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 Mark Kinman was found dead in his cell at HMP High Down on 17 October 2018. He had suffocated himself by placing a plastic bag over his head. He was 63 years old. I offer my condolences to Mr Kinman's family and friends.

I am satisfied that there was nothing to indicate that Mr Kinman intended to take his own life and that staff could not have reasonably foreseen his actions.

The investigation found that the officer who unlocked Mr Kinman's cell on the morning of 17 October failed to do a welfare check and therefore did not identify that Mr Kinman was unresponsive. It took another hour before his cellmate realised and alerted staff. The investigation also found that despite staff calling a medical emergency code when they found Mr Kinman, no ambulance was called.

Although these failings did not affect the outcome for Mr Kinman because it appears he had been dead for some time, the prison needs to ensure that unlock procedures are carried out correctly so that any welfare needs are identified and medical emergency procedures are followed.

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

Sue McAllister CB
Prisons and Probation Ombudsman **April 2019**

Contents

Summary 1

The Investigation Process 3

Background Information 4

Key Events 5

Findings 10

Summary

Events

1. On 20 August 2018, Mr Mark Kinman was remanded in prison custody, charged with firearms offences. He was moved to HMP High Down on 21 September.

2. On 13 October, Mr Kinman told a nurse that he felt depressed and asked for a GP appointment. The nurse made an appointment for 22 October.

3. On 15 October, Mr Kinman was moved to a different houseblock. He told a prisoner and an officer that he was worried he may not receive the goods he had ordered from the prison shop because he had been moved. The prisoner said Mr Kinman appeared very anxious but he tried to reassure him that the issue could be resolved easily.

4. Shortly after 8.00am on 17 October, an officer unlocked Mr Kinman's cell. She did not look through the observation panel or enter the cell. At around 8.55am, Mr Kinman's cellmate realised that Mr Kinman was unresponsive with a plastic bag over his head. Staff attended and radioed a medical emergency code at 8.57am. They did not attempt to resuscitate Mr Kinman as it was clear he was dead. At 8.59am, a paramedic confirmed Mr Kinman's death.

Findings

5. Following an investigation, the police were satisfied that Mr Kinman had taken his own life and that no one else was involved.

6. We are satisfied that Mr Kinman gave no indication that he intended to take his own life and that prison staff could not reasonably have foreseen his actions.

7. When Mr Kinman told a nurse he felt depressed, she booked a GP appointment 10 days in the future but did not ask him any questions to check whether he might be at risk of suicide. This would have been good practice.

8. Mr Kinman should have had a secondary health screen within seven days of arriving at High Down. Although staff made attempts to arrange this when they identified the oversight, it did not happen.

9. When unlocking a prisoner's cell, the officer is supposed to get a response from the prisoner to satisfy themselves that they have not escaped, are not ill or dead. This did not happen, which meant that no one realised that Mr Kinman was dead for another hour. We found that the unlock procedures were not carried out to a consistent standard at High Down and some officers seemed unclear about the correct process to follow. The Governor has since issued a reminder to staff.

10. Prison staff appropriately radioed a medical emergency code when they found Mr Kinman unresponsive. However, an ambulance was not called straightaway, contrary to local and national instructions. Although this did not affect the outcome in Mr Kinman's case because he was dead when found and an ambulance was not needed, it is important that the medical emergency procedures are followed so that in future, any delays are minimised.

Recommendations

- The Head of Healthcare should review the training of clinical staff in depression identification and introduce a brief checklist of questions and observation to exclude suicide risk.

- The Head of Healthcare should ensure:

    - there is an audit of successful completion of secondary health assessments within seven days of arrival; and
    - nursing staff are reminded that all relevant history from community medical records is recorded accurately.

- The Governor should ensure that control room staff call an ambulance immediately when a medical emergency code is called, in line with local and national guidance.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP High Down, informing them of the investigation and asking anyone with relevant information to contact her. One prisoner asked to speak to her during her initial visit.

12. The investigator visited High Down on 22 October, and obtained copies of relevant extracts from Mr Kinman's prison and medical records and visited Houseblocks One and Two. NHS England commissioned a clinical reviewer to review Mr Kinman's clinical care at the prison.

13. The investigator, accompanied by the clinical reviewer, interviewed five members of staff and two prisoners at High Down on 3 December. The investigator also interviewed a member of staff by telephone, and attempted to interview Mr Kinman's cellmate, but he had been released and was untraceable.

14. We informed HM Coroner for Surrey of the investigation. The coroner gave us the provisional cause of death. We have sent the coroner a copy of this report.

15. The Ombudsman's family liaison officer contacted Mr Kinman's family to explain the investigation. Mr Kinman's family did not raise any issues.

16. We shared our initial report with Her Majesty's Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and its action plan is annexed to this report.

17. We provided Mr Kinman's family with a copy of the initial report. They did not find any factual inaccuracies.

Background Information

HMP High Down

18. HMP High Down is a local prison in Surrey, which holds up to 1,150 men. Central and North-West London NHS Foundation Trust provides primary health services and in-reach mental health care. The healthcare unit has inpatient facilities with 24-hour nursing cover.

HM Inspectorate of Prisons

19. The most recent inspection of HMP High Down was in May 2018. Inspectors reported that standards had declined since the previous inspection, perhaps partly due to the uncertainty about the prison's future role and whether it was going to become a category C training prison. Inspectors found that analysis of violence was being developed but too little was being done to make the prison safer. Victims were not adequately supported and perpetrators were not effectively challenged.

20. Inspectors were concerned about the lack of purposeful activity with about 47% of prisoners locked in their cells during the working day. Inspectors found that support for those at risk of harm to themselves was variable and they found some examples of inadequate support for prisoners in crisis.

Independent Monitoring Board

21. 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 December 2017, the IMB noted that continuity of staff remained an issue because of the impact it had on staff's understanding and knowledge of prisoners, particularly in areas such as induction, with often insufficient numbers of experienced staff.

Previous deaths at HMP High Down

22. Mr Kinman was the12th prisoner to die at High Down since October 2015. Of these deaths, one was self-inflicted, 11 were from natural causes and one unascertained. There has been one death since, from natural causes. We have previously identified delays in requesting an ambulance in a medical emergency, which we repeat.

Assessment, Care in Custody and Teamwork

23. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or 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. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011*, Managing prisoners at risk from self, from others and to others (Safer Custody)*.

Key Events

24. On 20 August 2018, Mr Mark Kinman was remanded in prison custody, charged with firearms offences, and sent to HMP Lewes. This was not his first time in prison, although he had not been in prison for over 40 years.

25. Mr Kinman arrived at Lewes around 6.00pm. On his Person Escort Record (PER - a document that accompanies all prisoners when they move between police stations, courts and prisons which sets out the risks they pose), court staff had recorded there were no known risks and that Mr Kinman was due to appear at Kingston Crown Court in September. The reception documents from Lewes were not provided to the investigator, but there were no issues or concerns recorded on Mr Kinman's prison record. We understand that he intended to give evidence for the prosecution against his co-defendants.

26. At 9.06pm, a nurse recorded in Mr Kinman's medical record that he had completed his initial healthscreen. The nurse noted Mr Kinman had asthma and was prescribed pain relief (co-codamol) for joint problems. The nurse noted Mr Kinman had a high pulse, that he said he was anxious and concerned, but that he had had an 'eventful day'. The nurse recorded Mr Kinman had no thoughts of suicide or self-harm, but advised him how to access the Samaritans or Listeners (prisoners trained by the Samaritans to support other prisoners).

27. The reception nurse referred Mr Kinman to the prison GP because he was asthmatic, but there is no record that he was seen by a GP while at Lewes. Another nurse told the investigator that a GP appointment had been arranged for 28 August, but Mr Kinman was not seen and there was no explanation why. According to the medical records, Mr Kinman was not issued with an inhaler.

28. On 14 September, Mr Kinman appeared at Kingston Crown Court and was taken to HMP Wandsworth. At 6.40pm, an officer recorded that Mr Kinman said he should not be allowed to share a cell with his co-defendants, who were both at Wandsworth. There was no information to verify this on either the PER or Mr Kinman's security file.

29. A nurse completed Mr Kinman's healthscreen at 7.33pm. She recorded Mr Kinman had no thoughts of suicide or self-harm, had no mental health issues and appeared calm during his assessment. The nurse referred Mr Kinman to the prison GP for an asthma check. A prison GP assessed Mr Kinman at 8.15pm and prescribed an inhaler (salbutamol).

30. On 16 September at 9.44am, an officer recorded in Mr Kinman's prison record that he believed he should transfer back to Lewes, as he was not allowed to associate with his co-defendants. The officer granted Mr Kinman a public expense telephone call to his wife.

31. Mr Kinman was moved to HMP High Down on 21 September. A nurse completed Mr Kinman's healthscreen at 2.58pm. She recorded Mr Kinman used an inhaler for his asthma and had no thoughts of suicide or self-harm. The nurse referred Mr Kinman to the prison GP for an asthma check. The GP examined Mr Kinman at 3.32pm and prescribed his inhaler.

32. An officer completed Mr Kinman's first night induction at 4.11pm. Mr Kinman told the officer that he had been transferred from Wandsworth because of fears for his safety, but said he was also under threat at High Down. The officer spoke with a prison manager, who said that Mr Kinman should be located on a standard residential wing, and that he had been advised what to do if he did feel under threat. There is no evidence that Mr Kinman raised any further concerns while at High Down.

33. On 1 October, a nurse completed an older person health assessment and an asthma check. No issues were identified and Mr Kinman was given health advice on diet and exercise.

34. On 9 October, Mr Kinman applied to work in the textiles workshop. The next day, the workshop instructor spoke to a Senior Officer (SO) and asked her to speak to Mr Kinman to tell him that he would be welcome to join the workshop, but that it employed vulnerable prisoners (typically those in prison for sexual offences). Mr Kinman did not attend for work, and on 11 October at 9.12am, the workshop instructor removed his name from the workshop list. This was the last entry on Mr Kinman's prison record before he died.

35. On 13 October at 12.29pm, a nurse recorded on Mr Kinman's medical record 'c/o [complained of] low mood & depression – requesting to see GP – appointment made'. The nurse told the investigator that Mr Kinman approached her on the houseblock and asked her to make him a GP appointment. The nurse scheduled an appointment for 22 October and informed Mr Kinman immediately. The nurse said Mr Kinman showed no signs of concern either in how he spoke or through his body language.

36. On 15 October, Mr Kinman was moved from Houseblock One to Houseblock Two, to free up space for other prisoners on the induction unit. He was moved to A Spur, in a double cell, but was the only occupant. Prisoners and staff on the houseblock said Mr Kinman was polite but quiet and spent a lot of time in his cell.

37. The next day, Mr Kinman spoke to a custody information orderly (CIO - prisoners trained to assist other prisoners with issues on the houseblocks), and an officer as he was concerned that he would not receive his 'canteen' (goods ordered through the prison shop) because he had been moved. The CIO said that around 6.45pm, before all prisoners were locked up for the night, Mr Kinman asked him for help retrieving his canteen from Houseblock One. He said Mr Kinman appeared anxious and worried that his canteen would go missing, but he reassured him that as a CIO he would be able to go to Houseblock One the next morning and collect Mr Kinman's canteen and it would be an easy problem to solve. Mr Kinman asked him for a vape (nicotine replacement) but as he did not smoke he was not able to help, but offered him food, which he declined.

38. The CIO said that although Mr Kinman appeared a little upset and confused by the prison system, he never gave any indication of wanting to take his own life or being in crisis. He said that if he had had any concerns about Mr Kinman he would have told prison staff.

39. All prisoners' telephone calls, except those that are legally privileged, are recorded, and prison staff listen to a random sample. The investigator listened to

the calls Mr Kinman made between 24 September and 16 October, when he made his last call. In total he made 93 calls, totalling over 24 hours. Mr Kinman spoke to his wife several times a day. Although Mr Kinman said he struggled being in prison and that High Down was far worse than the last prison, there was nothing in the calls that suggested he was in crisis at High Down and he never spoke about taking his own life. He was worried about his wife as she had recently had a significant operation and needed care.

40. Mr Kinman was locked in his cell at around 7.00pm on 16 October. He telephoned his wife at 8.06pm and they spoke for just over 14 minutes. Unlike in previous telephone calls, Mr Kinman sounded upset. Mr Kinman's wife asked him if he was okay, and he replied that he was struggling being in prison. Mr Kinman said that he was worried he would not receive his canteen and that he had spoken to an orderly and an officer, but that he did not think he would get his order. Mr Kinman told his wife that he wished he could help her and that being in prison was like a 'living hell'. Mr Kinman's wife asked if she could do anything to support him, but he replied, 'no one can do anything'. Mr Kinman told his wife he loved her, but the call ended abruptly when his credit ran out.

41. At 10.46pm, a prisoner, who had just arrived at the prison, was put in the same cell as Mr Kinman. In his police statement, this prisoner said that when he entered the cell, he switched on the light and woke Mr Kinman. He said they shook hands and spoke briefly about why they were both in prison. The prisoner said he told Mr Kinman he was only serving seven days, and Mr Kinman said he was looking at a life sentence, but did not want to discuss his offences. He said that he made his bed up, closed the window because it was cold, and Mr Kinman gave him a jumper to wear. He said he went to sleep and did not wake up until the next morning.

Wednesday 17 October

42. At around 8.00am, two officers started to unlock cells on A Spur. Closed circuit television (CCTV) shows one of these officers unlocked Mr Kinman's cell without looking through the observation panel or entering the cell and quickly moved to the next door.

43. Prisoners were moving around the houseblock and some were playing table tennis outside Mr Kinman's cell. One of the men playing table tennis knocked over some water, and CCTV shows that he went into Mr Kinman's cell briefly, took a towel and used it to mop up the water. This woke Mr Kinman's cellmate, who swore at the prisoner and told him to get out of the cell. A short while later, around 8.53am, Mr Kinman's cellmate left the cell and walked onto the houseblock. He told Surrey Police that he just left the cell and did not look behind him or check if Mr Kinman was awake.

44. CCTV shows around 8.55am, an officer placed a letter inside Mr Kinman's cell, but he did not enter. He told the investigator he assumed Mr Kinman was asleep and did not want to disturb him. Mr Kinman's cellmate went into the cell, picked up the letter and went to hand it to Mr Kinman. The prisoner said he realised when he touched Mr Kinman's arm that he was cold, that his arm was blue and then he noticed Mr Kinman had a clear plastic bag over his head. CCTV shows

him calmly left the cell and walked up the stairs and he told officers that he thought his cellmate was not breathing and might be dead.

45. An officer responded, immediately followed by the officer who unlocked the cell. They entered the cell and at 8.57am, the first officer radioed a code blue medical emergency (used to indicate a prisoner is unconscious or having breathing difficulties). He ripped open the plastic bag and was joined by two other officers. The other officer left the cell and, assisted by an SO, started to lock up the prisoners who were on the houseblock.

46. The officers tried to move Mr Kinman to the floor before they started cardiopulmonary resuscitation (CPR) but because of his size were unable to move him. While staff were trying to move Mr Kinman, a paramedic employed by the healthcare provider and based at High Down, arrived and instructed staff not to start CPR as it was clear Mr Kinman was dead. The paramedic said there were obvious signs that Mr Kinman had been dead for some time: he had rigor mortis, his blood had pooled and he was very cold. At 8.59am, the paramedic declared that Mr Kinman had died. A prison GP, arrived at Mr Kinman's cell at 9.17am and certified his death.

47. Surrey Police were satisfied that Mr Kinman had taken his own life and that no one else had been involved.

48. Two letters dated 16 October, addressed to Mr Kinman's wife and daughter, were found after his death. Although he described feeling low and worried about his canteen going to the wrong houseblock, there was nothing in the letters to indicate he intended to take his own life.

Contact with Mr Kinman's family

49. The prison appointed a family liaison officer (FLO) and another member of staff as her deputy. Surrey Police made the decision to inform Mr Kinman's family of his death, without discussing their intention with prison staff. (The police have since updated their procedures to ensure this does not happen again.)

50. The Governor, FLO and her deputy went to the family home at 11.45am. They spoke to Mr Kinman's family, who were provided with ongoing support by the FLO and her deputy. The prison contributed towards the costs of Mr Kinman's funeral, in line with national policy.

Support for prisoners and staff

51. The Governor held a hot debrief, although not all staff involved were present. Most staff said they felt well supported and the Post-Incident Care Team spoke to everyone involved.

52. The prison posted notices informing other prisoners of Mr Kinman's death, and offering support. Staff reviewed all prisoners considered to be at risk of suicide and self-harm, in case they had been adversely affected by Mr Kinman's death.

Cause of death

53. The coroner gave Mr Kinman's provisional cause of death as plastic bag asphyxia (suffocation). The post-mortem and toxicology reports were not available at the time of issuing this report.

Findings

Assessment and management of Mr Kinman's risk of suicide and self-harm

54. Prison Service Instruction (PSI) 64/2011, *Managing prisoners at risk of harm from self, from others and to others* (*Safer Custody)*, lists several risk factors and potential triggers for suicide and self-harm. Mr Kinman had some risk factors. Although he had previous experience of prison, he had not been in prison for 40 years, so this was akin to his first time in prison. He was charged with a serious offence and if found guilty faced a long prison sentence. In addition, Mr Kinman believed that he may be under threat because he had spoken to the police about his co-defendants' involvement in the alleged offences and planned to give evidence for the prosecution. However, Mr Kinman was assessed by prison and healthcare staff and gave no indication that he was at risk of suicide or self-harm. We are satisfied that prison staff could not have reasonably foreseen his actions.

55. Mr Kinman's community medical record noted that he suffered from brief episodes of depression in 1997, 1999 and 2011, but did not require specialist services. When Mr Kinman approached a nurse on his houseblock and asked her to book him an appointment with the prison doctor she said he was very well presented and did not look like he was neglecting himself. The nurse said she had been a general nurse for over 30 years and had completed suicide awareness training, although had not completed any formal training in identifying depression. She said she did not ask Mr Kinman any specific questions about why he felt depressed because they were not in a confidential area and he appeared in a rush. The clinical reviewer concluded that, in the absence of any pressing concern, Mr Kinman would have received a similar response in a community setting but that the introduction of a simple depression questionnaire that all staff could complete would be beneficial. We make the following recommendation:

    The Head of Healthcare should review training of clinical staff in depression identification and introduce a brief checklist of questions and observation to exclude suicide risk.

Clinical care

56. PSO 3050 – *Continuity of healthcare,* states all prisoners that arrive in prison custody should have an initial healthscreen while in reception, and if appropriate, be referred to the doctor to assess their physical and mental health needs, including any medication they may be prescribed.

57. The clinical reviewer concluded that overall Mr Kinman's clinical care was good and equivalent to that which he could have expected to receive in the community. There were no issues or concerns relating to his physical healthcare and his pre-existing medical conditions were identified and managed appropriately and promptly. However, Mr Kinman should have had a secondary health screen within seven days of transfer to High Down, but this did not happen. The oversight was identified by the healthcare team and they attempted to assess Mr Kinman on 16 October, but they were unable to locate him as he had moved to a different houseblock.

58. Mr Kinman's community medical record was requested, received promptly and reviewed. However, there is no record of a summary being made about previous episodes of depression. The records rely on Mr Kinman self-reporting his previous history; he did not report a past history of depression at his reception interview. We therefore make the following recommendation:

The Head of Healthcare should ensure:

- **there is an audit of successful completion of secondary assessments within seven days of arrival; and**
- **nursing staff are reminded that all relevant history from community medical records is recorded accurately.**

Unlock procedures

59. When officers unlock cells, they should take active steps to check on a prisoner's wellbeing. The Prison Officer Entry Level Training (POELT) manual states: "Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead."

60. Prison Service Instruction 75/2011 Residential Services states:

"Reports from the Prisons and Probation Ombudsman on deaths in custody have identified cases in which a prisoner has died overnight … but staff unlocking them have not noticed that the prisoner had died. This is not acceptable...

"[Differing] arrangements will depend on the local regime, but there need to be clearly understood systems in place for staff to assure themselves of the well-being of prisoners during or shortly after unlock ... 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."

61. On 17 October, when the officer unlocked Mr Kinman's cell, she should have checked his welfare and obtained a response from him. The officer said she normally would just unlock the cell door and then pull the door to, so it was not wide open because most prisoners were still in bed with the lights off. Another officer said he understood unlock to involve the office briefing before prisoners were unlocked and then counting prisoners. Neither officer recalled being trained in obtaining a response at unlock.

62. Prisoners interviewed said being asked for a response in the morning differed across houseblocks, and that some officers did, but not all. Having spoken to many officers, the investigator concluded that it was accepted practice for staff at High Down not to routinely obtain a response from prisoners when unlocking cells and some officers did not know they were required to do so.

63. The investigator told the Governor about these findings and on 12 December, the Governor issued a Notice to Staff (143/2018), reminding staff that they must

check prisoners' wellbeing when they unlock cells. Given the Governor's swift response to our feedback, we do not make a recommendation.

Emergency Response

64. PSI 3/2013 - *Medical Emergency Response* requires prisons to have a medical emergency response code protocol, which contains mandatory instructions for governors and directors to provide guidance on efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance.

65. High Down's local protocol, Governor Information Notice (GIN) 24/2017 reissued on 22 March 2017, is clear that an ambulance should be called immediately when a medical emergency code is radioed, in line with PSI 3/2013. In addition, GIN 118/2017 issued on 8 December 2017, advises staff that Surrey Ambulance Service introduced changes to ambulance response categories to ensure that their response to High Down is appropriate. In line with this information, High Down introduced Emergency Response Information Cards (E.R.I.C) to assist staff in calling an appropriate medical emergency code and providing the information requested by ambulance control centres.

66. The officer promptly and appropriately radioed a code blue medical emergency when he found Mr Kinman. An operational support grade (OSG) working in the control room, recorded on the communications log that a code blue medical emergency had been called at 8.57am. In his police statement he said he attempted to contact the officer over his radio to obtain more information about the situation, but got no response. The OSG said at around 9.00am, a prison manager, arrived at the communications room and he asked if he should request an ambulance, but she said, as Mr Kinman had been declared dead, an ambulance was not required.

67. An ambulance should have been requested immediately when the code blue was called. During the investigation it became apparent that it was not uncommon for the communications room to wait for the emergency response nurse to confirm if an ambulance was required before calling one. This is not in line with guidance. Although it did not affect the outcome in Mr Kinman's case, there could be cases where any delay in requesting an ambulance could be crucial. In another recent investigation at High Down, we found that there was a delay before control room staff requested an ambulance following a medical emergency code. We therefore make the following recommendation:

    The Governor should ensure that control room staff call an ambulance immediately when a medical emergency code is called, in line with local and national guidance.

68. Staff did not start CPR when they found Mr Kinman because they were certain he was dead. The decision not to start CPR was appropriate and preserved Mr Kinman's dignity in the circumstances.

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100
F I 020 7633 4141