Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Martin Mahon a prisoner at HMP Birmingham on 27 September 2018

## 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 Martin Mahon died of heart disease on 27 September 2018 at HMP Birmingham. He was 51 years old. I offer my condolences to Mr Mahon's family and friends.

Overall, the care that Mr Mahon received at Birmingham was equivalent to that which he could have expected to receive in the community.

I am concerned that the prison officers who found Mr Mahon unresponsive on the floor did not consider opening his cell door and did not radio a medical emergency code blue promptly.

I have made a number of previous recommendations about staff responding inappropriately to emergencies and I am now very concerned that this continues to be an issue. I am therefore escalating this matter to the Prison Group Director for the West Midlands to ensure that action is taken to address this unsatisfactory state of affairs.

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

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

## Contents

# Summary

## Events

1. On 24 January 2013, Mr Martin Mahon was sentenced to six years in prison for burglary. He was released on licence but recalled to prison after he breached his licence terms. On 18 July 2018, he was admitted to HMP Birmingham.

2. Mr Mahon had a history of bipolar disorder and schizoid personality disorder. He was dependant on opioids, used cannabis and drank half a litre of vodka a day. He had heart disease and had had a cardiac bypass operation in 2017.

3. A prison GP re-prescribed his medication which included buprenorphine (an opioid used to treat opiate addiction).

4. On 24 August, Mr Mahon was transferred to HMP Stoke Heath in error. He did not attend an appointment with a consultant forensic psychiatrist that day. The next day, he was moved back to Birmingham because at that time, the Integrated Drug Treatment Strategy (IDTS) team at Stoke Heath did not prescribe buprenorphine.

5. At about 2.00am on 27 September, an operational support grade smelled burning near Mr Mahon's cell. She opened the cell door observation panel and saw that Mr Mahon was "messing with the kettle or phone wires". She did not speak to Mr Mahon but fetched a colleague. They both saw that Mr Mahon was standing in his cell, playing with wires.

6. One of the operational support grades telephoned the night orderly officer who was in the central office. The night orderly officer and an officer went to the wing. The officer went to Mr Mahon's cell, looked through the cell door observation panel and saw Mr Mahon sitting on the floor in an upright position, with his back against the bed and his chin resting on his chest. The officer said that it looked like Mr Mahon had fallen asleep. The night orderly officer went to the cell and also looked through the observation panel. He believed that Mr Mahon might have been under the influence of a psychoactive substance (PS) and told the officer to get a nurse.

7. At about 2.32am, the officer walked to another wing to collect the night shift duty nurse (who did not have a key) and they returned to Mr Mahon's cell. The night orderly officer opened the cell door and went in with the nurse who checked for signs of life. Mr Mahon did not have a pulse and was not breathing. The officer radioed the control room and asked them to call for an ambulance.

8. The nurse and officers started cardiopulmonary resuscitation (CPR) and continued resuscitation attempts until paramedics arrived and took over. At 3.24am, paramedics pronounced that Mr Mahon had died. The post-mortem examination established that he died of heart disease.

## Findings

9. Except for an inappropriate transfer to HMP Stoke Heath (which resulted in him missing a psychiatric appointment and a dose of buprenorphine), the clinical reviewer found that the care that Mr Mahon received at Birmingham was equivalent to that which he could have expected to receive in the community. We are satisfied that the transfer did not have an impact on Mr Mahon's death.

### Events of 27 September 2018

10. The operational support grade, who first saw Mr Mahon in his cell, should have spoken to him and asked him what he was doing. Although we recognise that at this stage, there was no indication that there was a medical emergency, there was a smell of burning and she saw Mr Mahon play with wires. In this context, she should also have radioed the night orderly officer to attend the wing.

11. We are concerned that the officer who saw Mr Mahon in his cell on the floor did not consider that he might have required urgent medical attention. We are also concerned that the night orderly officer who then saw Mr Mahon in the same position on the floor did not consider opening the cell door, even though Mr Mahon was unresponsive and he thought that he might be under the influence of PS.

12. Without physically checking Mr Mahon, there was no way for the officer and night orderly officer to know if he was breathing. We are concerned that the officer did not go into the cell to check and then radio a medical emergency code blue (which indicates that a prisoner is unconscious or not breathing). While we recognise that the nurse did not have a key to access the prison wings and had to be escorted by the officer, this delayed Mr Mahon's emergency medical treatment.

13. We consider that it is important for staff who were involved in Mr Mahon's care to see the findings of and learn lessons from our investigation.

## Recommendations

- The Governor should ensure that staff understand that when there is potentially a risk to life and subject to a personal risk assessment, they should enter a cell at night and radio an appropriate emergency code.

- The Prison Group Director for the West Midlands should satisfy herself that effective measures have been taken to address Birmingham's continuing failure to enter a cell and radio an appropriate emergency code when there is a potential risk to life.
- The Governor should ensure that operational support grades receive appropriate training to understand their roles and responsibilities during night state and that they fully understand why they are issued with a night pouch and the circumstances when it should be used.

- The Governor and Head of Healthcare should ensure that any staff named in this report are given the opportunity to read the report at the draft stage in line with paragraph 1.11 of PSI 58/2010.

## The Investigation Process

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

15. The investigator obtained copies of relevant extracts from Mr Mahon's prison and medical records.

16. The investigator interviewed a member of staff by telephone on 17 June and three members of staff at Birmingham on 18 June.

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

18. We informed HM Coroner for Birmingham and Solihull of the investigation. She gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

19. The investigator tried to contact Mr Mahon's sister, his next of kin, but was unable to make contact.

20. We shared the initial report with the Prison Service. There was one factual inaccuracy, this report has been amended accordingly.

# Background Information

## HMP Birmingham

21. HMP Birmingham is a local prison which holds up to 1,450 prisoners. Birmingham and Solihull Mental Health Foundation Trust provides 24-hour healthcare services at the prison and sub-contract Birmingham Community Healthcare NHS Trust to provide primary care services, including a 15-bed healthcare unit. The segregation unit at Birmingham is known as the Care and Separation Unit and comprises 13 cells.

## HM Inspectorate of Prisons

22. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Birmingham during the week of 30 July 2018, which found the prison to be fundamentally unsafe. On 16 August 2018, HMIP invoked the Urgent Notification (UN) process which committed the Secretary of State to respond publicly to the concerns raised within 28 calendar days. Key findings from the inspection included:

- Levels of violence had increased and when measured over the last 12 months, were the highest for any local prison in the country.
- 71% of prisoners said that they felt unsafe at some time in Birmingham. 37% felt unsafe at the time of the inspection and many reported being bullied or victimised.
- Prisoners were isolating themselves in their cells, refusing to emerge because of their fear of violence. Virtually nothing was being done to support them.
- There was a tenuous lack of control. Accounting for prisoners was poor, with wing staff often not knowing where prisoners were.
- Many prisoners were under the influence of drugs and the smell of cannabis and other burning substances pervaded many parts of the prison. Over half the population thought that drugs were easy to obtain. One in seven said that they had developed a problem with illicit drugs since they had been in Birmingham. The trafficking of illegal substances was blatant. It was shocking that many staff did not seem prepared to tackle the drugs misuse.
- Many staff lacked both confidence and competence in key prison skills. Wings were poorly supervised and prisoners routinely disregarded rules, even to the extent of open drug use.
- Living conditions were as poor as seen anywhere in recent years and staff and managers appeared to have become inured to the decay in standards.

## Independent Monitoring Board

23. 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 June 2018, the IMB

reported that recruitment and retention of staff had improved with a full complement of staff by June 2018. They noted that violence had stabilised but were concerned about the lack of consistency in imposing sanctions on perpetrators of violence. They found that hospital appointments were often cancelled when other unplanned priorities arose. The IMB found that Birmingham offered appropriate care for prisoners with mental health but that the abuse of PS continued to challenge safety and stability.

## Previous deaths at HMP Birmingham

24. There have been 18 deaths at Birmingham in the last two years, 12 of which were from natural causes, four of which were self-inflicted and two were drug-related. In our investigations into five of these deaths, we identified poor emergency responses and the failure to radio a medical emergency code. Birmingham agreed to implement our recommendations to address these issues. The Governor has accepted these recommendation's and action plans have been prepared to improve prison practice.

## Psychoactive substances (PS)

25. Psychoactive substances (formerly known as 'new psychoactive substances' or 'legal highs') are a serious problem across the prison estate. They are difficult to detect and can affect people in a number of ways, including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

26. In July 2015, we published a Learning Lessons Bulletin about the use of PS (at that time, known as NPS) and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

27. HM Prison and Probation Service (HMPPS) now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements.

# Key Events

28. On 24 January 2013, Mr Martin Mahon was sentenced to six years in prison for burglary. He went to hospital for a mental disorder and spent a period of time on licence which was revoked on 11 August 2016, when he was recalled to custody. On 18 July 2018, he was admitted to HMP Birmingham.

29. On 18 July, a nurse completed Mr Mahon's initial health screen and noted that he had a history of bipolar disorder and schizoid personality disorder. She noted that he was dependant on opioids, used cannabis and drank half a litre of vodka a day. He said that he had heart disease and had had a cardiac bypass operation in 2017.

30. A prison GP re-prescribed his medication which included buprenorphine and a nurse referred him to the IDTS.

31. On 19 July, a nurse from the IDTS saw Mr Mahon and agreed a detoxification and management plan. She referred him to the Drug and Alcohol Recovery Team (DART). At 1.02pm, a nurse saw Mr Mahon in his cell because he had chest pains. He told her that he had just smoked heroin. She gave him naloxone (to block the effects of opioids). A prison GP reviewed him and took an electrocardiogram (ECG) which showed a normal heart rhythm.

32. At 2.05am on 20 July, a nurse saw Mr Mahon in his cell because he again had chest pains. She noted that Mr Mahon's blood pressure was high (150/92). She planned to monitor him and that if there were any concerns, she would send him to hospital.

33. Later that day, a nurse from the primary care mental health team saw Mr Mahon. She noted that he showed no signs of mental illness and had no thoughts of suicide or self-harm. She referred him to the mental health inreach team because he had seen them in the community and his care was handed to the IDTS team.

34. On 31 July, a nurse saw Mr Mahon in his cell because he had had pain in his chest, left shoulder and left arm for the past four hours. Because Mr Mahon had a low pulse rate (40 beats per minute) and a history of heart disease, she thought that he might be having a heart attack. Mr Mahon was sent urgently to hospital by ambulance. He remained in hospital for five days for monitoring and tests. A consultant cardiologist noted that Mr Mahon's slow pulse rate was due to his bisoprolol medication (used to treat high blood pressure and heart failure) which he stopped taking while in hospital.

35. On 16 August, a nurse from the inreach team saw Mr Mahon who said that his current depot medication was not working well. She referred Mr Mahon for a review with a psychiatrist and planned to review his medication.

36. On 24 August, Mr Mahon was transferred to HMP Stoke Heath and was therefore unable to attend an appointment with a consultant forensic psychiatrist, that day. The next day, he returned to Birmingham because the IDTS team at Stoke Heath did not prescribe buprenorphine. Mr Mahon was

distressed and annoyed because he had missed his dose of buprenorphine at Birmingham.

37. The Head of the Offender Management Unit (OMU) said that an administrative error occurred where Mr Mahon's prison details were incorrectly entered which led to him being transferred by mistake. However, this was identified by HMP Stoke Heath on the day of transfer and he was sent back to HMP Birmingham.

38. The Head of Healthcare said that Stoke Heath refused to allow buprenorphine in the prison at the time. Because Mr Mahon had an incorrect prisoner number listed and nursing staff only checked by name, they did not identify that Mr Mahon should not have been transferred. She said that the IDTS team have since changed their process to check both prisoner numbers and names to avoid such mistakes in the future.

39. On 19 September, a nurse reviewed Mr Mahon because a DART worker was concerned about him. She spoke to a second nurse who saw Mr Mahon. He told her that he was hearing voices and asked to have his depot medication re-started. The second nurse noted that he did not plan to self-harm and saw no signs that his mental health was worsening. She planned for him to be seen by a psychiatrist.

### Events of 27 September 2018

40. At about 2.00am on 27 September, Operational Support Grade (OSG) smelled an unfamiliar 'burning smell' coming from Mr Mahon's cell. She opened his cell door observation panel, saw that the cell light was on and that Mr Mahon was standing beside his desk, opposite the bed, next to his pin phone, television and kettle and that he was holding wires. Mr Mahon looked at her, but she said that he did not appear to be concerned that she was there.

41. She said that she did not speak to Mr Mahon because he looked perfectly fine and there was no emergency. She fetched her colleague from an adjacent wing. They both saw that Mr Mahon was still standing in his cell, with the wires in his hands and they could both smell the same smell.

42. At about 2.25am, an OSG telephoned the night orderly officer, a Senior Officer (SO) who was in the centre office and told him what they had seen. She said that she had a radio but chose to use the telephone because it was not an emergency. The SO said that there did not seem to be any urgency at that stage, but he went to Mr Mahon's wing, with an officer. The SO spoke to the OSG while the officer went to Mr Mahon's cell.

43. The officer looked through the cell door observation panel of Mr Mahon's cell and saw him sitting on the floor, with his back against the bed. He said that it did not look like Mr Mahon had collapsed, or that he was unconscious and he was not clutching his chest. He said that his chin was on his chest and it looked like he had gone to sleep. He said that he could not see if he was breathing. He said that he did not try to rouse him, he did not kick the door, he just glanced at him and went to get another SO for a second opinion. The second officer said that something was not quite right, and he did not know why Mr Mahon had gone to sleep on the floor.

44. He went to the wing office and asked the SO to have a look. They went to the cell and looked through the observation panel. The SO said that it looked as if Mr Mahon had had "some kind of reaction". He said that he could clearly see him breathing and there was no sign of blood or vomit around his mouth or anything that would cause him any concern. However, because of the way he was slumped, he thought that he would get the nurse to do a welfare check. The SO told the officer to get a nurse.

45. The SO said that it took about three to four minutes for a nurse to arrive at the cell and during that time, he could clearly see that Mr Mahon's chest was moving so he had no concerns at that stage. The SO suspected that Mr Mahon may have taken PS. He said that he did not radio the nurse because she did not have a set of keys to cross the prison, so an officer had to escort her. The SO said that he tried to get a response from Mr Mahon by banging on the door and shouting his name. He thought that he was either in a very deep sleep or was having some kind of reaction to a drug.

46. The officer walked to another wing, about a minute's walk, where he saw, the night shift duty nurse, and they walked back to Mr Mahon's cell. At 2.35am, when they arrived at the cell, the SO opened the door and went in with the nurse who checked for signs of life. Mr Mahon did not have a pulse and was not breathing.

47. The SO radioed the control room and asked for an ambulance to be called. He said that because he believed it was quicker to ask for an ambulance, he did not use a code blue. The officer then went to the wing office where he telephoned the control room and told the officer that there was a prisoner who might be dead and that they were doing CPR.

48. At 2.36am, an officer in the control room telephoned the ambulance service.

49. The nurse placed Mr Mahon on his back and started chest compressions. An officer took over chest compressions. The nurse said that there were no signs of cyanosis (blue or purple colour) to his lips or extremities, that he was warm to the touch and that there were no signs of rigor mortis. She noticed that there was a small amount of vomit in the toilet.

50. The nurse tried to insert a tube into Mr Mahon's airway, but it was blocked with fluid, so she used oxygen and suction to try to clear the fluid. She used a defibrillator and, on several occasions, it indicated that there were non-shockable rhythms. An officer took over chest compressions.

51. At 2.41am, an ambulance arrived at the prison and paramedics were promptly at Mr Mahon's side. The nurse continued chest compressions before paramedics took over resuscitation attempts. At 3.24am, paramedics said that Mr Mahon had died.

### Examination of electrical equipment

52. On 26 October, a chartered electrical engineer, assessed the fixed wiring system of the cell where Mr Mahon died. He found that attempts had been made to dismantle the television set but the reason for this was unclear. He said that the television had an adequate level of protection for both basic and

fault protection. He said that the electrical distribution and earthing systems, including the fixed wiring system within the cell, was adequate and electrically safe. He found no evidence of the occurrence of an electrical shock from the electric system or the electrical appliances.

### Contact with Mahon's family

53. On 27 September, the Head of Safer Custody appointed a training manager as the family liaison officer (FLO) and an officer as the deputy family liaison officer.

54. The Head of Safer Custody and the FLO's made numerous enquiries to trace Mr Mahon's next of kin. When he went to Birmingham, Mr Mahon said that his daughter was his next of kin, but she was a minor.

55. At 12.45pm, the Head of Safer Custody, the FLO and a chaplain saw Mr Mahon's sister at her home, told her that Mr Mahon had died and offered their condolences. A Custodial Manager (CM) told another of Mr Mahon's daughters, a prisoner at HMP Drake Hall, that he had died and offered her condolences. A chaplain told Mr Mahon's son, a prisoner at HMP Manchester, that he had died and offered his condolences. On 2 November, the FLO and a CM took Mr Mahon's sister to see his body at a hospital.

56. The Head of Safer Custody remained in frequent contact with Mr Mahon's sister, the FLO remained in contact with Mr Mahon's daughter at Drake Hall and a chaplain remained in contact with Mr Mahon's son at Manchester who was later transferred to HMP Woodhill.

57. Mr Mahon's funeral took place on 23 March 2019. Managers at Drake Hall and Woodhill refused permission for Mr Mahon's daughter and son to attend the funeral for security reasons. Birmingham contributed to the funeral costs in line with national instructions.

### Support for prisoners and staff

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

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

### Post-mortem report

60. A post-mortem examination found that Mr Mahon died of heart disease. Post-mortem toxicology test results showed that he had buprenorphine and other prescribed substances in his system at levels consistent with therapeutic use. There was no evidence that he had taken PS or any other illicit substances.

# Findings

## Clinical care

61. The clinical reviewer noted that the care that Mr Mahon received at Birmingham was equivalent to that which he could have expected to receive in the community.

62. Mr Mahon was dependant on heroin, used cannabis and drank half a litre of vodka a day. Healthcare staff at Birmingham promptly started a detoxification programme and the clinical reviewer said that this was well managed from a physical and mental health perspective.

63. When Mr Mahon had chest pains in August, he was appropriately transferred to hospital for assessment and treatment. The care that healthcare staff provided to Mr Mahon was timely and he was appropriately referred to IDTS, DART and inreach services.

64. The clinical reviewer makes a number of recommendations which are not related to Mr Mahon's death and are therefore not repeated here.

## Transfer to Stoke Heath

65. On 24 August, Mr Mahon was inappropriately transferred to HMP Stoke Heath due to a system error. This caused him to miss a dose of buprenorphine and an appointment with a consultant psychiatrist. The clinical reviewer said that this aspect of Mr Mahon's care was not equivalent to that which he would receive in the community because there was no feedback system in place between the referrer and the service referred to.

66. We are satisfied that the Head of Healthcare has taken appropriate steps to ensure that the correct identity of a prisoner is established by checking both the name and prisoner number.

67. The clinical reviewer makes a recommendation about the failed transfer. We do not repeat it here because it did not directly relate to Mr Mahon's cause of death.

## Events of 27 September 2018

68. PSI 24/2011 on management and security at nights requires that all prisoners are locked in their cells during night state. Under normal circumstances, the night orderly officer must give authority to unlock a cell during night state, and no cell should be opened unless at least two or three members of staff are present, one of whom should be the night orderly officer. However, the PSI states that the preservation of life must take precedence. It says that where there is, or appears to be, immediate danger to life, cells may be unlocked without the authority of the night orderly officer and an individual member of staff may go into the cell on their own. However, night staff should not take action that they feel would put themselves or others in unnecessary danger.

69. The PSI states that before going into a cell, staff should make every effort to get a verbal response from the prisoner. This, together with what the member

of staff observes through the panel and any knowledge of the prisoner, should inform a rapid dynamic risk assessment of the situation and a decision about whether to enter immediately or wait for assistance. Birmingham's local policy for opening cells at night is the same as the PSI.

70. The operational support grade who smelled burning outside Mr Mahon's cell and saw him playing with wires should have spoken to him and asked what he was doing. She should have used her radio to ask the night orderly officer to come to the wing. However, we recognise that there were initially no signs of a medical emergency, Mr Mahon died of natural causes and no illicit substances were identified in his system after his death. We therefore make no recommendation.

71. We are concerned that when an officer looked through Mr Mahon's cell door observation panel, he thought nothing more than that he was asleep on the floor and did not consider whether he might require urgent medical attention. When the night orderly officer then looked through the observation panel, the officers should have opened the cell door, physically checked on Mr Mahon and tried to get a response from Mr Mahon, particularly as his position on the floor gave the night orderly officer enough cause for concern to ask for a nurse to attend.

72. Mr Mahon was unresponsive and as they did not physically check him, they could not have known whether or not he was breathing. The officer told the investigator that he did not use a code blue because "it is a bit more relaxed on nights". We consider that the officers should have immediately entered the cell to check on Mr Mahon and called a code blue when they found that he was not breathing. Their failure to do so caused a delay in the emergency response and in an ambulance being called. We make the following recommendation:

**The Governor should ensure that staff understand that when there is potentially a risk to life and subject to a personal risk assessment, they should enter a cell at night and radio the appropriate emergency code.**

73. We have made a number of previous recommendations, which Birmingham agreed to implement, about staff responding inappropriately to emergencies. We are concerned that this continues to be an issue, and we are therefore escalating this matter to the Prison Group Director for the West Midlands to ensure that action is taken. We make the following recommendation:

**The Prison Group Director for the West Midlands should satisfy herself that effective measures have been taken to address Birmingham's continuing failure to enter a cell and radio an appropriate emergency code when there is a potential risk to life.**

74. We are satisfied that once the nurse arrived at the cell, resuscitation efforts were prompt and an ambulance was called without further delay.

75. The operational support grades told the investigator that they had not received any training about how to use their night pouches. We are also concerned

that the officer and the night orderly officer, both of whom were experienced officers, did not consider that they should have opened the door before the nurse arrived. We consider that there is an urgent training need at Birmingham and we make the following recommendation:

**The Governor should ensure that operational support grades receive appropriate training to understand their roles and responsibilities during night state and that they fully understand why they are issued with a night pouch and the circumstances when it should be used.**

### Sharing our report with staff

76. We consider that it is important for staff who were involved in Mr Mahon's care to see the findings of and learn lessons from our investigation. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that any staff named in this report are given the opportunity to read the report at the draft stage in line with paragraph 1.11 of PSI 58/2010.**

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