Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Dominic Phoenix a prisoner at HMP Isle of Wight on 10 November 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*
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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 Dominic Phoenix was found dead in his cell at HMP Isle of Wight on 10 November 2018. He had left a note in which he said that he had taken an overdose of prescription medication. He died from amitriptyline intoxication (which had been prescribed to him). Mr Phoenix was 44 years old. I offer my condolences to his family and friends.

Mr Phoenix was serving a long sentence and had said at his previous prison that the distress of losing both his job and contact with his family had made him want to take his life. As a result, he was managed under suicide and self-harm procedures (known as ACCT) for his first few months in prison.

With hindsight, it appears that Mr Phoenix planned his suicide carefully. However, he appeared to have settled well into life at HMP Isle of Wight and prisoners and staff who knew him did not foresee that he would take his life.

Mr Phoenix's death is a reminder of the stresses that prisoners serving long sentences can face, and which, to a large extent, Mr Phoenix seems to have hidden at Isle of Wight. I consider that there was little to indicate to staff that he was at imminent risk of suicide and it would have been difficult to predict Mr Phoenix's actions.

I am, however, concerned that staff appear to have had very little interaction with Mr Phoenix and that this would have limited their ability to get to know and support him.

I am also concerned that the decision to allow him to have his medication in his possession did not take sufficient account of his risk factors.

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 **May 2019**

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Summary

Events

1. Mr Dominic Phoenix was remanded in custody to HMP Elmley on 22 November 2017, charged with sexual offences. He had harmed himself the previous day and said at court that he would do so again given the opportunity. Prison staff opened suicide and self-harm prevention procedures, known as ACCT, when he arrived.

2. In his first two months at Elmley, Mr Phoenix often said that he intended to take his life as he had lost his job, family and freedom. On 8 January 2018, he was sentenced to 24 years in prison. In the weeks after this, Mr Phoenix repeated his threats to take his life and said that he would do so at the right time. In February, he appeared to settle more into prison life and prison staff stopped ACCT procedures on 13 February.

3. On 22 March, Mr Phoenix was transferred to HMP Isle of Wight. A prison nurse assessed that it was appropriate for him to keep medication in his cell, to take as prescribed. On 4 April, he told a prison doctor that he had migraines and had found amitriptyline a helpful preventative medicine in the past. (Amitriptyline is prescribed for a variety of reasons, including to prevent migraine attacks, nerve pain and as an antidepressant.) The doctor prescribed this, initially at a low dose. He reviewed Mr Phoenix frequently over the following months, and slowly increased the dose until Mr Phoenix said that the medication was effective.

4. Staff and prisoners who knew Mr Phoenix said that he appeared to be settled in prison and had a job he enjoyed. He obtained the enhanced level of the Incentives and Earned Privileges scheme and did not speak about harming himself or wishing to take his life.

5. At around 6.40am on 10 November, an officer conducting a count of prisoners became concerned for Mr Phoenix's welfare. He and a colleague spent around five minutes trying to obtain a response from Mr Phoenix before concluding that they had seen his lower back move. The first officer returned to the cell at around 8.30am and was still concerned. Three officers then opened Mr Phoenix's cell and found that he had died.

6. Mr Phoenix left a note indicating that he had taken an overdose of amitriptyline. The post-mortem and toxicology reports confirmed that he had died from amitriptyline intoxication.

Findings

7. Mr Phoenix had some risk factors for suicide and self-harm, and had appropriately been managed under ACCT procedures in his first weeks in custody.

8. With hindsight, it appears that Mr Phoenix, who had been a nurse before entering prison, deliberately sought and stockpiled amitriptyline with the intention of taking his life. Nevertheless, we are satisfied that in the days and weeks leading to his death, there was nothing to indicate that he was at increased risk of suicide and

self-harm. We consider that it would have been difficult for staff at Isle of Wight to have foreseen his death.

9. However, there is little evidence that prison staff had frequent meaningful contact with Mr Phoenix and we are therefore concerned that they did not give themselves the best opportunity to identify any issues he might have had. Isle of Wight is now implementing a new offender management model, which provides time for staff to have weekly sessions with each prisoner. We have not, therefore, made a recommendation about this.

10. We are concerned that the nurse who assessed Mr Phoenix's suitability to keep medication in his cell did not fully consider his risk factors, including his recent self-harm.

11. We are concerned that staff did not open Mr Phoenix's cell earlier on the morning of 10 November when they had significant concerns for his welfare.

Recommendations

- The Head of Healthcare should ensure that staff completing medication in-possession risk assessments consider all relevant information, including about recent self-harm.
- The Governor should ensure that staff responsible for completing roll checks satisfy themselves that each prisoner is alive and well.

The Investigation Process

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

13. The investigator obtained copies of relevant extracts from Mr Phoenix's prison and medical records. He interviewed five members of staff and four prisoners at Isle of Wight in December 2018.

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

15. We informed HM Coroner for Isle of Wight of the investigation. She provided copies of the post-mortem and toxicology reports. We have sent the Coroner a copy of this report.

16. One of the Ombudsman's investigators wrote to Mr Phoenix's ex-partner to explain the investigation and to ask if she had any matters that she wanted us to consider. She did not respond.

17. We shared the initial report with HM Prison and Probation Service (HMPPS). They did not find any factual inaccuracies.

Background Information

HMP Isle of Wight

18. HMP Isle of Wight is an amalgamation of two former prisons, Parkhurst and Albany, and holds approximately 1,100 men. Care UK provides healthcare services at the prison. There is a healthcare inpatient unit at the former Albany site, providing 24-hour care for prisoners. There is no healthcare cover during the night at the Parkhurst site, where Mr Phoenix lived.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Isle of Wight was in May to June 2015. Inspectors reported that the number of self-harm incidents was higher than at similar prisons, but prison staff provided good care for those at risk of self-harm. They also found that the relationships between staff and prisoners were good and that the personal officer scheme was effective. Most prisoners sampled said that they had a member of staff to turn to if they had a problem.

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 December 2017, the IMB reported an 88 per cent increase in incidents of self-harm compared to the previous year. They also reported that prison staff provided fair and equitable treatment for all prisoners.

Previous deaths at HMP Isle of Wight

21. Mr Phoenix was the twentieth prisoner to die at Isle of Wight since November 2015, and the third prisoner to apparently take his own life. In our investigation into the death of a man in January 2018, we found that prison staff did not open and enter the prisoner's cell as quickly as they should in an emergency.

Assessment, Care in Custody and Teamwork

22. 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. 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.

23. 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. 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

24. On 21 November 2017, Mr Dominic Phoenix was arrested on suspicion of committing serious sexual offences against a child and not completing previous bail requirements. He had never previously been convicted of an offence or been sent to prison. Before his arrest, Mr Phoenix tried to stab himself in the right side of his head, which he said was an attempt to take his life.

25. On 22 November, Mr Phoenix appeared in court and was remanded in custody to HMP Elmley. Mr Phoenix said at court that he might try to harm himself if he had the opportunity. Court staff completed a suicide and self-harm warning form, in which they also described Mr Phoenix's actions of the previous day.

HMP Elmley

26. A nurse assessed Mr Phoenix when he arrived at Elmley. He recorded that Mr Phoenix had said that he had tried to kill himself the previous day, and noted a "very superficial" graze on the side of his head. The nurse began ACCT procedures. Mr Phoenix told the nurse that he was prescribed citalopram and mirtazapine (both are antidepressants) - but had stopped taking them as he found them unhelpful - and sumatriptan (disposable injections used as required for migraines). A prison doctor prescribed mirtazapine.

27. At an assessment the next day, Mr Phoenix said that he considered himself not guilty and had lost everything in the last two years. He said that he had been suspended from his job as a mental health nurse and was not allowed to live with his family. Mr Phoenix said that his current circumstances made him feel suicidal.

28. At ACCT case reviews in December, Mr Phoenix continued to say that he had thoughts of ending his life, although as the month went on, he began to say that they were more fleeting. He also said that he would not cope if he received a long sentence.

29. On 30 December, a nurse completed a mental health triage assessment. Mr Phoenix said that he had depression and low mood, and that the mirtazapine that he was prescribed was not effective. He said that he had thoughts of taking his life and had tried to strangle himself in his cell the previous night. The nurse referred Mr Phoenix to the prison doctor for a medication review, and arranged for the frequency of his ACCT observations to be increased.

30. On 8 January 2018, Mr Phoenix was sentenced to 24 years in prison. On his return from court, he said that he had a plan to end his life but did not give details.

31. On 11 January, a nurse assessed Mr Phoenix's mental health. Mr Phoenix said that he did not want any alternatives to mirtazapine as he did not think medication would help him.

32. The next day, a nurse assessed Mr Phoenix. She recorded that he was very low in mood but did not present with any acute mental health issues. Mr Phoenix said that he had no protective factors to live for as he had lost his job, his family and his freedom. The nurse referred Mr Phoenix to counselling groups and he

was put on their waiting list. She agreed with Mr Phoenix that he would have no further input from the mental health team at that time.

33. On 17 January, Mr Phoenix told a Supervising Officer (SO) that he intended to kill himself if he had the chance as his life had no meaning. The SO emailed the mental health team to inform them. When Mr Phoenix repeated his comments on 19 January, he was admitted to the healthcare centre inpatient unit for assessment.

34. On 20 January, a mental health nurse assessed Mr Phoenix. Mr Phoenix said that he had thoughts of taking his life, as he had lost everything, and was simply waiting for the right time. Mr Phoenix also repeated that he did not take mirtazapine as he did not find it effective.

35. On 23 January, a consultant psychiatrist assessed Mr Phoenix. He concluded that there was no clear evidence of psychosis or any other mental illness. He noted that Mr Phoenix said that he had thoughts of suicide, and there was an ongoing risk of self-harm, but he had no clear plan or intent to take his life and these thoughts were unrelated to mental illness. The psychiatrist recommended that Mr Phoenix should be discharged from the inpatient unit, that they stop prescribing mirtazapine, and that there was no further need for input from the mental health team. He prescribed a short course of zopiclone to help Mr Phoenix sleep.

36. At an ACCT case review on 24 January, Mr Phoenix said that he intended to take his life at some time, but had no plan in mind and did not think that he would do anything at Elmley. Mr Phoenix said that he had no family support in prison but had built a network of friends on his wing.

37. On 7 February, Mr Phoenix told an ACCT case review that he still had occasional thoughts of suicide but had no plans to act on them. He said that he felt more positive and had taken steps to becoming a Listener (a prisoner trained by the Samaritans to support other prisoners).

38. At an ACCT case review on 13 February, Mr Phoenix said that he was in a better frame of mind and felt more positive. He said that he had had no recent thoughts of harming himself and had no active plan to do so. An SO stopped ACCT procedures.

39. On 12 March, Mr Phoenix attended his first counselling session. At his second session, a week later, he told the counsellor that he did not think he needed the sessions. She told Mr Phoenix how to reapply if he changed his mind.

HMP Isle of Wight

40. On 22 March, Mr Phoenix was transferred to HMP Isle of Wight. An officer interviewed him on arrival and noted his previous self-harm and ACCT history. The officer recorded that there was no current indication or evidence for ACCT monitoring.

41. A nurse assessed Mr Phoenix in reception. He recorded that Mr Phoenix appeared well and said that he had no thoughts of harming himself. He recorded that Mr Phoenix had not self-harmed or attempted suicide in the last 12 months.

The nurse noted that Mr Phoenix was not currently prescribed any medication but would be suitable to keep it in his cell to take as prescribed if this changed.

42. On 4 April, Mr Phoenix told a prison GP that he had severe migraines and nausea. Mr Phoenix said that he had previously found amitriptyline useful as a preventative medication and that he would like to try it again. The GP prescribed a low dose of 10mg tablets of amitriptyline. (Amitriptyline is prescribed for a variety of reasons, including prevention of migraine attacks, nerve pain, and as an antidepressant. It is available in 10mg, 25mg and 50mg tablets.) He also prescribed prochlorperazine (an anti-emetic medication to prevent nausea).

43. On 26 May, an officer completed a personal officer entry in Mr Phoenix's prison records. He recorded that Mr Phoenix received positive reports from staff and mixed well with other prisoners. He noted that Mr Phoenix worked in Island Design (a graphic design workshop in the prison) and was on the enhanced level of the Incentives and Earned Privileges (IEP) scheme (which aims to encourage and reward responsible behaviour in prisons). The officer recorded that Mr Phoenix regularly spoke to his family and friends by telephone. (This is incorrect as Mr Phoenix did not make any telephone calls or receive any visits at Isle of Wight.) He noted that Mr Phoenix had no issues or concerns that required attention.

44. On 4 June, a prison GP reviewed Mr Phoenix, who said that the amitriptyline was ineffective. He increased the dose to one 25mg tablet per day. The GP also prescribed sumatriptan injections, for Mr Phoenix to use as required to relieve pain when a migraine started.

45. On 2 July, the prison GP reviewed Mr Phoenix again. Mr Phoenix said that the sumatriptan injections worked well for acute attacks, but the amitriptyline was still not effective at prevention. He said that he had previously taken a 50mg dose in the community, which he found effective. The GP agreed to increase the dose to two 25mg tablets per day.

46. On 23 July, the prison GP reviewed Mr Phoenix again. Mr Phoenix said that his "background headache", which he felt continuously, had improved but he still had migraines. The GP increased Mr Phoenix's amitriptyline prescription to two 50mg tablets per day. Mr Phoenix received a one-week supply of amitriptyline to keep in his cell and take as required. This meant that he now received 14 tablets every week.

47. On 23 August, Mr Phoenix received a letter from the Nursing and Midwifery Council, informing him that he had been removed from their register and would not therefore be able to work as a mental health nurse. On the same day, an officer spoke to Mr Phoenix and recorded that he was well and had no issues.

48. The next day, the prison GP reviewed Mr Phoenix. He recorded that Mr Phoenix had shown good improvement since they increased the dose of amitriptyline and now reported weekly, rather than daily, migraines. He noted that Mr Phoenix appeared well and in good mood, and that they agreed not to change the current dose.

49. On 30 September, an officer completed a personal officer entry. He recorded that Mr Phoenix was mature, positive and willing to engage and help others. Mr Phoenix said that he had no contact with his family, but had some email contact with friends.

50. On 24 October, an SO, Mr Phoenix's offender supervisor, gave him a letter from the Disclosure and Barring Service (a government department that considers whether individuals should be barred from engaging in work or other regulated activity with vulnerable groups, including children), which informed him that he would not be able to return to his previous career as a mental health nurse. The SO told us that Mr Phoenix already knew this and it was not a surprise to him. He said that Mr Phoenix did not identify any problems or issues when they spoke.

51. Mr Phoenix lived in a single cell on Houseblock 20 at Isle of Wight, a standard residential unit. Prisoners who knew him told us that he was doing well in prison and did not have any problems. They said that Mr Phoenix enjoyed his work at Island Design. They said that Mr Phoenix sometimes socialised with them but at other times would keep to himself, particularly if he had a migraine. They said that Mr Phoenix did not appear to change in the weeks before his death.

Events of 9-10 November 2018

52. On 9 November, Mr Phoenix collected a repeat prescription of amitriptyline. Later that day, wing staff told the prisoners that they would be unlocked later than usual the next morning because of a staff event. A prisoner who was friends with Mr Phoenix, told us that Mr Phoenix said, "See you in the morning" shortly before they were locked in their cells, and that everything appeared normal.

53. An operational support grade (OSG), worked overnight on Houseblock 20 on 9-10 November. He completed a count of prisoners at around 5.30am. He told us that Mr Phoenix was in bed and appeared to be asleep. The OSG told us that he understood that a purpose of the count was to ensure that a prisoner was not ill and that he should view movement or obtain a response before moving on.

54. At around 6.20am, an officer relieved the OSG. The officer had only recently completed training and was in his second week working as a prison officer. He completed a count of prisoners, and arrived at Mr Phoenix's cell at around 6.40am. The officer told us that he could not tell whether Mr Phoenix was breathing. He therefore asked another officer who was working on the neighbouring houseblock, to check.

55. The second officer told us that he spent around five minutes looking into Mr Phoenix's cell, during which time he banged on the door to try to get a response. He said that he then identified movement in Mr Phoenix's lower back, and was therefore satisfied that he was well. The first officer said that he then looked into the cell again and could also see the movement that the second officer had described. Both Officer's said that they did not consider opening Mr Phoenix's cell at this point as they were satisfied that they had seen him breathing.

56. At around 8.20am, the first officer returned to check on Mr Phoenix. He recorded that Mr Phoenix was lying in the same position as before, and told us that he spent several minutes banging on the door, trying to wake Mr Phoenix. The

officer then returned to the wing office and asked two other officers to come to Mr Phoenix's cell. A third officer opened the cell and found that Mr Phoenix was not breathing. He radioed a medical emergency code blue. The control room operator recorded this call at 8.32am, and telephoned for an ambulance.

57. The first officer told us that they did not try to resuscitate Mr Phoenix as he appeared stiff (indicating the presence of rigor mortis) and blue in the face and they considered that he had died. Paramedics arrived at Isle of Wight at around 8.55am and recorded that Mr Phoenix had died.

58. Mr Phoenix left a note in his cell in which he said that he had taken an overdose of amitriptyline. He wrote that he could no longer cope with prison and felt scared all of the time. Mr Phoenix also wrote that he had lost everything in his life, and thanked prison officers for trying to help him.

Contact with Mr Phoenix's family

59. A prison family liaison officer (FLO) and an SO visited Mr Phoenix's ex-partner on 10 November, and informed her of his death. Isle of Wight contributed to the costs of the funeral in line with Prison Service instructions.

Support for prisoners and staff

60. After Mr Phoenix's death, the Head of Security 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.

61. The prison posted notices, informing other prisoners of Mr Phoenix's death and offering support.

Post-mortem report

62. Post-mortem and toxicology reports identified the cause of death as amitriptyline intoxication.

Findings

Identifying risk of suicide and self-harm

63. Prison Service Instruction (PSI) 64/2011, which governs ACCT suicide and self-harm prevention procedures, requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures. We have considered whether staff at HMP Isle of Wight should have recognised Mr Phoenix as at risk and started ACCT procedures.

64. When he was first sent to prison, Mr Phoenix was subject to ACCT monitoring for nearly three months at HMP Elmley. He told staff at Elmley that he intended to take his life when he had the opportunity, and often spoke of having suicidal thoughts. Staff stopped ACCT procedures when Mr Phoenix appeared to have settled more positively into prison life and said that he no longer had suicidal thoughts or an active plan to take his life.

65. Following his transfer to Isle of Wight, there is no record that Mr Phoenix ever spoke of having any further thoughts of taking his life. There is no intelligence that he used illicit drugs in prison and none were identified in the toxicology examination. He had some risk factors for suicide and self-harm, particularly a long sentence and lack of contact with his family. However, no one who met Mr Phoenix in the weeks before his death considered that he was at increased risk, and staff and prisoners alike described his death as unexpected. We are therefore satisfied that it was reasonable for staff to have concluded that he did not pose a risk of suicide or self-harm, which warranted ACCT monitoring, in the weeks leading to his death. We do not consider that staff could reasonably have predicted his actions.

Relationships between staff and prisoners

66. Mr Phoenix left a note in which he said that he could not cope with prison and felt scared all of the time. During his time at Isle of Wight, there were very few entries in Mr Phoenix's case notes about his welfare. Mr Phoenix had a personal officer, but he made only three entries during the seven months that Mr Phoenix was at the prison. While more meaningful contact would not necessarily have identified Mr Phoenix's concerns, this was a missed opportunity to recognise this and any other underlying issues that he might have had.

67. We are pleased that Isle of Wight has begun to implement a new offender management model as part of a national roll-out. This includes every prisoner having a keyworker who will be their first point of contact and assist them with any difficulties they have in prison, with an expectation that the keyworker spends 45 minutes with the prisoner every week. We hope that it will assist in lessening the distress felt by prisoners like Mr Phoenix in the future. We therefore make no recommendation but record our concern at a troubling lack of meaningful engagement between staff and the prisoners in their care.

Clinical care

68. Mr Phoenix had frequent contact with the mental health team at Elmley, because of his clear suicidal intent when he first came into prison. The clinical reviewer noted that mental health professionals of various disciplines reviewed him and discharged him when they found that he did not have any significant mental health issues. The clinical reviewer found that Mr Phoenix received appropriate care for his mental health in prison, equivalent to that which he could have expected to receive in the community.

69. Mr Phoenix took his life by taking an overdose of amitriptyline, which he was prescribed at Isle of Wight for migraines. The clinical reviewer noted that he was regularly reviewed by the same prison doctor, and that Mr Phoenix gave a convincing account of his migraine and the need for an increased dose. He found that the prison GP enquired about Mr Phoenix's mood before prescribing an increased dose. With hindsight it appears that Mr Phoenix, who had been a nurse before entering prison, deliberately sought and stockpiled amitriptyline with the intention of taking a fatal overdose. However, the clinical reviewer concluded that the GP prescribed amitriptyline appropriately for Mr Phoenix's reported symptoms and equivalently to that which he would expect in the community.

70. When Mr Phoenix arrived at Isle of Wight, a nurse assessed whether it was appropriate for him to keep medication in his cell to take as prescribed. The assessment consists of several questions to determine whether there are any factors that might present a risk. This includes questions about any recent history of self-harm or suicide attempts, whether ACCT procedures are open, whether the prisoner has been bullied for or known to have traded medication, and whether there are any physical or mental ill health issues that might affect their capacity to take medication as required.

71. The nurse concluded that Mr Phoenix was suitable to keep medication in his cell. However, in making this judgement he incorrectly recorded that Mr Phoenix had not harmed himself or attempted suicide in the past year. If he had correctly identified Mr Phoenix's recent self-harm and ACCT, the nurse might have concluded that it was not yet appropriate for him to keep medication in his possession.

    The Head of Healthcare should ensure that staff completing medication in-possession risk assessments consider all relevant information, including about recent self-harm.

Events of 10 November

72. The purpose of a roll check is to ensure that all prisoners are accounted for, but also to check that they are alive and well. National instructions in PSI 24/2011 say that staff have a duty of care to prisoners, to themselves and other staff. The preservation of life must take precedence over usual arrangements for opening cells and where there is, or appears to be, immediate danger to life, then cells may be unlocked without the authority of the night orderly officer and an individual member of staff can enter the cell on their own.

73. From the officers' descriptions of Mr Phoenix at around 8.30am, it is likely that rigor mortis had begun to occur. Rigor mortis can occur from within two to six hours of death. It is therefore possible that Mr Phoenix was already dead at the two earlier roll checks, at 5.30am and 6.40am.

74. Two officers spent around five minutes looking into Mr Phoenix's cell at around 6.40am. They banged on the door but Mr Phoenix did not respond. After around five minutes, they thought that they could see movement in Mr Phoenix's lower back, indicating that he was breathing. As noted, it is possible that he was either dead or close to dying at this time. Given the length of time they spent trying to rouse Mr Phoenix before they thought they identified a response, we consider that the officers should have opened the cell to check on Mr Phoenix's welfare.

75. While we cannot be sure whether more thorough checks on Mr Phoenix's wellbeing at 5.30am and 6.40am would have affected the eventual outcome, it is possible they may have done. We make the following recommendation:

The Governor should ensure that staff responsible for completing roll checks satisfy themselves that each prisoner is alive and well.

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