Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Alan Doward a prisoner at HMP Manchester on 19 January 2019

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 Alan Doward was found hanged in his cell at HMP Manchester on 19 January 2019. He was 57 years old. I offer my condolences to Mr Doward's family and friends.

I am satisfied that in the weeks leading up to his death, Mr Doward gave no indication that he was at imminent risk of suicide and that staff could not reasonably have foreseen or prevented his actions.

I am concerned, however, that when Mr Doward arrived at Manchester on 26 September, staff failed to properly assess his risk of suicide and self-harm despite him having several known risk factors. They also failed to refer him for a mental health assessment.

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 **September 2019**

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Summary

Events

1. On 26 September 2018, Mr Alan Doward was remanded in prison custody, charged with drug offences. He was sent to HMP Manchester. This was his first time in prison.

2. Mr Doward had a history of depression and had previously self-harmed. However, Mr Doward did not display any signs that he was in crisis at Manchester and told staff he had no thoughts of suicide or self-harm. Prisoners who knew him said he appeared 'down' at times, but were not unduly concerned and did not think he was at risk of suicide.

3. Shortly after 5.04am on 19 January 2019, during the early morning roll check, an officer discovered Mr Doward hanging in his cell. The officer radioed a code blue medical emergency, entered the cell and, with the assistance of prison and healthcare staff, tried to resuscitate Mr Doward. When ambulance paramedics arrived, they assessed that Mr Doward had been dead for some time and recorded his death at 5.25am.

Findings

4. We are satisfied that in the weeks leading up to his death, Mr Doward gave no indication that he intended to take his own life and that prison staff could not reasonably have foreseen or prevented his actions.

5. However, we are concerned that reception staff at Manchester did not properly assess Mr Doward's risk of suicide and self-harm when he arrived on 26 September. There is no evidence they considered the information in his Person Escort Record (PER) or his disclosure of a history of self-harm.

6. Reception staff also failed to refer Mr Doward for a mental health assessment as they should have done given his history of self-harm and depression.

7. There were clear signs that Mr Doward was dead when found so staff should not have tried to resuscitate him. Not all prison and healthcare staff were aware of national guidance on when it is inappropriate to attempt resuscitation.

8. We are concerned that there were no healthcare staff present at the debrief held after Mr Doward's death.

Recommendations

- The Governor and Head of Healthcare should produce clear guidance about procedures for identifying prisoners at risk of suicide and self-harm. In particular, this should ensure that reception, healthcare, first night staff and all others who assess risk:

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

- Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide and self-harm, including information from the Person Escort Record (PER) and other sources.
- Document the information considered and the reasons for the decision on whether or not to open an ACCT.

- The Head of Healthcare should ensure that all prisoners with a history of mental ill health and/or self-harm are properly identified, reviewed and referred for a primary mental health assessment.

- The Governor and Head of Healthcare should ensure that staff are given clear guidance and check their understanding about the circumstances in which resuscitation is inappropriate in accordance with European Resuscitation Council Guidelines.

- The Governor should ensure that all relevant staff, including healthcare staff, are invited to the debrief following a death in custody.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Manchester, 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.

10. The investigator visited Manchester on 23 January, and obtained copies of relevant extracts from Mr Doward's prison and medical records and visited G Wing.

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

12. The investigator accompanied by the clinical reviewer, interviewed seven members of staff and one prisoner at Manchester on 26 February. The clinical reviewer also interviewed a nurse on 5 March.

13. We informed HM Coroner for City of Manchester District of the investigation. We have sent the coroner a copy of this report.

14. One of the Ombudsman's family liaison officers, contacted Mr Doward's next of kin, his partner, to explain the investigation. Mr Doward's partner wanted to know if Manchester were aware he had previously attempted to take his own life and if any special measures were in place to support him. We have addressed her concerns in this report.

15. Mr Doward's next of kin received a copy of the initial report, but did not identify any factual inaccuracies.

16. The prison received a copy of the report; they corrected the name of the healthcare provider and identified an incorrect name, which we have amended.

Background Information

HMP Manchester

17. HMP Manchester operates as both a high security prison and as a local prison serving the courts of the Greater Manchester area. It can hold more than 1,200 men. Greater Manchester Mental Health NHS Foundation Trust provides 24-hour nursing.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Manchester took place in June and July 2018. Inspectors reported that compared to their last inspection in 2014, where the prison achieved reasonably good outcomes against their healthy prison tests, at this inspection there had been a deterioration on most outcomes. Inspectors noted self-harm had increased since their last inspection, although work to address recommendations following investigations into previous deaths was reasonable.

19. Inspectors found prisoners in reception said they had been treated well by staff. However, the identification of risk factors in relation to safety and protected characteristics was crude and inadequate, often limited to basic cell-sharing risk assessments.

20. While most healthcare staff had received training in suicide and self-harm awareness, few had received mental health awareness training, despite it being available from the Trust.

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 published annual report for the year to 28 February 2018, the IMB noted that 50% of residential wings did not have the desired levels of staff on duty and the fabric of the building was generally in poor condition. They described the healthcare provision as excellent.

Previous deaths at HMP Manchester

22. Mr Doward was the 14th prisoner to die at Manchester since January 2017. Of the previous deaths, five were self-inflicted, seven were from natural causes and one awaits classification. There have been two deaths since, one self-inflicted and one awaiting classification. We have previously made recommendations about the need for healthcare staff to understand when mental health referrals are appropriate and to ensure all information about risk is considered when prisoners arrive at Manchester.

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 of harm to self, to others and from others (Safer Custody)*.

Key Events

24. On 26 September 2018, Mr Alan Doward was remanded in prison custody, charged with drug offences, and taken to HMP Manchester. This was his first time in prison.

25. Mr Doward arrived at Manchester around 3.00pm. 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 that Mr Doward had been charged with possession of a Class A drug, had a heart condition and had suffered from depression in March 2016.

26. At 5.21pm, a nurse recorded in Mr Doward's medical record that he had completed his initial healthscreen. The nurse noted Mr Doward had heart disease and had had a stent inserted in April 2017, suffered from gout (inflammation caused by uric acid deposits) and had a few other minor physical health issues. The nurse recorded that Mr Doward said he had harmed himself approximately four years earlier (no detail recorded) but had no current thoughts of suicide or self-harm. At 6.18pm, the reception GP recorded Mr Doward's mood was normal and continued his prescribed medication for his heart (aspirin and bisoprolol), stomach acid (lansoprazole) and pain relief. Mr Doward took his medications as prescribed.

27. An officer completed Mr Doward's reception screening at 6.14pm. The officer recorded on the cell sharing risk assessment (CSRA) that Mr Doward was not to associate with his two co-defendants and that he had told Mr Doward what to do if he had any issues. Mr Doward declined a move to the vulnerable prisoner unit for his own protection. Mr Doward told the officer that he had no thoughts of suicide or self-harm and had no immediate concerns. Mr Doward tried to telephone his partner from reception, but there was no answer. The nurse completed the health assessment section of the CSRA and noted that there were no factors present that increased Mr Doward's risk. He marked 'N/A [not applicable]' against the question 'Available medical records have been accessed'.

28. An officer completed Mr Doward's basic custody screening at 6.19pm and noted that he had concerns about his finances and accommodation, but had no thoughts of suicide or self-harm. At 7.15pm, an officer completed Mr Doward's first night induction when he said he was concerned he had not spoken to his partner.

29. The next day at 9.40am, a member of staff from the chaplaincy, completed her reception talk. Mr Doward told her he had no thoughts of suicide or self-harm, that he expected to have regular visits but had not yet spoken to his partner. At 3.55pm, an officer completed Mr Doward's second day interview and noted Mr Doward was waiting for his PIN telephone to be set up and that he had still not spoken to his partner.

30. On 8 October, a nurse completed Mr Doward's secondary healthscreen. Mr Doward raised no concerns and he declined to be referred for smoking cessation.

31. On 25 October, Mr Doward was given an IEP warning by a member of staff from education for failing to attend on 23 October, but there is no information recorded as to why Mr Doward did not attend.

32. On 17 December, an officer introduced herself as Mr Doward's keyworker (they should get to know the prisoners they are responsible for, act as a first point of contact for any problems, help with resettlement issues and make regular entries in prisoners' records about their progress). Mr Doward told the officer how he had come to be in prison, that he had lost contact with his immediate family, but had regular visits from his partner. The officer noted that Mr Doward worked as a wing cleaner and had numerous positive reports for his work and attitude. The officer made a further entry on 23 December, to note how helpful Mr Doward had been on the wing.

33. On 27 December, the officer met with Mr Doward for their second keyworker session. She recorded Mr Doward was in 'good spirits' although struggled being away from his partner over Christmas. Mr Doward spoke about how he became involved in his offence, but was optimistic about transferring to a different prison after he was sentenced. Mr Doward said he was having a few problems with his cellmate and he struggled sharing a cell with someone half his age. On 30 December, staff approved enhanced IEP status for Mr Doward.

34. On 31 December, Mr Doward asked to speak to his keyworker. She noted in his prison record at 3.43pm, that he had asked to move to C Wing as he found it too hectic on G Wing and wanted to move to a quieter wing and 'keep his head down'. The officer recorded that she had arranged for him to be placed on the list for a wing move. This was the last entry on Mr Doward's prison record before he died. (C Wing was being refurbished and half of the wing was out of use at the time of Mr Doward's request. Prisoner numbers were reduced in December and the plan was to start the refurbishment mid-January 2019.)

35. On 14 January, Mr Doward moved to cell G3-15, a double cell but he was the sole occupant, on G Wing. An officer told the investigator that he regularly spoke to Mr Doward, typically about football but that Mr Doward also spoke about his partner. The officer said he spoke to Mr Doward after his cell move and asked why he had moved and checked on his welfare. Mr Doward told him that his previous cellmate was younger and had his television and radio on all night, and that he just wanted time on his own. The officer said that he had no inclination that Mr Doward was particularly down or that his risk of suicide and self-harm had increased.

36. 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 Doward made from his in-cell telephone between 9 November 2018 and 18 January 2019, when he made his last call. In total he made 380 calls to his partner (not all were answered), totalling over 11 hours. Mr Doward typically spoke to his partner several times a day and the calls were usually upbeat and chatty. During a telephone call on 16 January, Mr Doward told his partner he was not in a good place, that he was not sure he can 'do it [prison]' and that he had nothing to live for without her. Mr Doward sounded emotional and told his partner how much he missed her. He asked his partner for reassurance that she

loved him as, if she didn't, he would 'do something stupid'. Mr Doward spoke to his partner a short while later to apologise, said that he needed to 'man up' and told her that he just liked to speak to her.

37. On 18 January at around 5.00pm, an officer locked Mr Doward in his cell. Once in his cell, Mr Doward made 28 telephone calls to his partner during the evening, 26 of which were not answered. At 4.58pm, they spoke for just under two minutes. Mr Doward did not sound distressed, and his partner told him that she was going out for the evening but would speak to him later. At 8.51pm, Mr Doward spoke to his partner for a further two minutes and asked her about her evening out. He told her that he had had his haircut in anticipation of her next visit. Mr Doward sounded anxious when his partner said her birthday card had not arrived, and she told him to stop worrying as it was causing her stress. Mr Doward said he did not like being in his cell, but did not sound unduly concerned or distressed. The call ended abruptly as Mr Doward had reached his maximum call time.

Saturday 19 January

38. At around 5.04am, an officer and an Operational Support Grade (OSG), started the early morning roll check on G Wing. Closed circuit television (CCTV) shows the officer looked through the observation panel of Mr Doward's cell, immediately shouted to the OSG and radioed an emergency code blue (used to indicate a prisoner is unconscious or having breathing difficulties). The officer broke the seal on her key pouch and, followed by the OSG, entered Mr Doward's cell at 5.05am.

39. Mr Doward was discovered hanging by a belt attached to the end of his bunk bed. He had also cut both arms near his elbows and the insides of his ankles. The officer used her anti-ligature knife to cut the belt, while the OSG supported Mr Doward's weight. A Custodial Manager (CM) and a second officer, who had responded to the emergency code, lowered Mr Doward onto the bed, before moving him to the floor to start cardiopulmonary resuscitation (CPR). Two nurses arrived at Mr Doward's cell at 5.06am, with two other officers (one who activated her body worn video camera). A nurse attached an automatic defibrillator, which indicated that Mr Doward had no shockable rhythm but staff continued CPR until paramedics arrived. Mr Doward's jaw was stiff which prevented nurses inserting an airway, but an oxygen mask was used.

40. North West Ambulance Service records show they received a request for an ambulance at 5.05am. When paramedics arrived at 5.24am, they assessed Mr Doward and at 5.25am declared that he had died. Paramedics noted Mr Doward had cuts to his arms and ankles, that rigor mortis and hypostasis (blood pooling which occurs after death) were present and Mr Doward was beyond resuscitation.

41. Two letters were found in Mr Doward's cell, addressed to his partner. Mr Doward wrote that he was devastated that she would not answer his calls, that he could not live without her and did not want to be a burden to her. Mr Doward said he hated himself for how things had worked out. Mr Doward had also posted a card and letter to his partner which was intercepted in the internal post. It was her birthday the day he died. In this letter dated Thursday 17 January, Mr Doward described being locked in his 'dungeon' since 6.00pm the previous evening as

the prison was on lock down until further notice [there was a power outage between 17-22 January, when not all services could be provided] and that the telephones were not working. Mr Doward said it did not bother him being locked up, as long as the telephones were back on by the weekend. The letter continued the next day, after Mr Doward had spoken to his partner. He said that he felt lonely now he had spoken to her, and that the prison was 'vile' as prisoners were banging, shouting and screaming because of the continued lock down. There is nothing specific in the letters that indicated Mr Doward intended to take his own life.

42. A Listener, who was also a friend of Mr Doward, said that although at times Mr Doward appeared a little down, as many prisoners often did, 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 Doward he would have told prison staff.

43. Another friend of Mr Doward, described him as 'down' and that he struggled being in prison and missed his partner, but never thought Mr Doward was suicidal. He said that he was aware Mr Doward became anxious when he could not speak to his partner on the telephone. He said that the night before Mr Doward died, he was in his cell chatting to him. He said Mr Doward showed him photographs which he put up in his cell and had also had a shave and a haircut. He said in hindsight he wondered if Mr Doward had already planned to take his own life.

Contact with Mr Doward's family

44. The prison appointed a family liaison officer (FLO). The FLO informed Mr Doward's partner of his death at 12.30pm, and provided ongoing support. The FLO also spoke to Mr Doward's family and provided information about the circumstances of his death. The prison contributed towards the costs of Mr Doward's funeral, which was held on 1 February, in line with national policy.

Support for prisoners and staff

45. A CM debriefed the prison staff involved in the emergency response and offered support. Healthcare staff were not invited to the debrief. Healthcare staff were supported by their healthcare provider. Most staff said they felt well supported and the Post Incident Care Team spoke to prison staff who discovered Mr Doward.

46. The prison posted notices informing other prisoners of Mr Doward'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 Doward's death.

47. Prisoners on G Wing had a collection for Mr Doward's partner and prayers were said in the chapel on Sunday 20 January.

Post-mortem report

48. The post-mortem report was not available at the time of issuing this initial report.

Findings

Assessment of Mr Doward's risk of suicide and self-harm

49. We consider that Mr Doward gave no indication that he was at imminent risk of suicide in the weeks leading up to his death and that staff could not reasonably have foreseen or prevented his actions. However, we are concerned that when Mr Doward arrived at Manchester on 26 September 2018, reception staff failed to consider the information that arrived with him and failed to properly assess his risk of suicide and self-harm.

50. PSI 07/2015, *Early Days in Custody*, states that it is a mandatory requirement for staff to manage prisoners appropriately who arrive with an indication that they might be at risk of suicide and self-harm. PSI 07/2015, requires that the PER and any other available documentation must be examined in reception to assess the risk of self-harm or harm to others by the prisoner, or harm from others and states: 'The completed Person Escort Record (PER) form that must accompany each new prisoner, and any other available documentation, must be examined in Reception to identify any immediate needs and risks already recorded.' Staff did not properly consider the information on Mr Doward's PER, which noted: 'Depression - 1/3/16' in the health-related risks section. The prison did not, therefore, comply with this instruction.

51. PSI 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, states that, after speaking to a prisoner, staff should use their judgement in combination with all available evidence to inform their decision as to whether a prisoner poses a risk to himself. Both instructions list a number of risk factors and triggers that might increase a prisoners' risk of suicide and self-harm. PSI 64/2011 also sets out the procedures (known as ACCT) that staff must follow when managing prisoners at risk of suicide and self-harm.

52. When he arrived at Manchester on 26 September, a number of these factors were relevant to Mr Doward: it was his first time in custody, he was on remand and had a history of depression and self-harm. Although we do not know whether this would have affected the outcome for Mr Doward, there is little evidence these risk factors were fully considered.

53. A nurse did not recall Mr Doward. He said he did not routinely have sight of the transfer documents from police custody, including the PER, but relied on prison colleagues to pass on relevant information. The nurse recorded in Mr Doward's medical record that he disclosed an incident of self-harm four years earlier, but the entry lacked detail. There was no consideration given to referring Mr Doward for a mental health assessment or to obtain more detail about the circumstances surrounding this incident.

54. In a thematic report about risk factors in self-inflicted deaths published by the Prisons and Probation Ombudsman in April 2014, we identified that too often reception assessments placed too much weight on staff's perception of the prisoner and they did not consider all relevant information. We reinforced these messages in a Learning Lessons Bulletin, issued in February 2016, about early days and weeks in custody. None of the staff or prisoners who had contact with

Mr Doward during his time at Manchester considered him to be at risk of suicide or self-harm because he appeared 'okay'. A prisoner's presentation can reveal something of their level of risk. However, it is only a reflection of their state of mind at the time they are seen by the member of staff and should be considered as a single piece of evidence used to make a judgement of risk. All risk factors must be collated and considered to ensure that a prisoner's level of risk is judged holistically

55. We conclude that it would have been difficult for any staff to have identified an increase in Mr Doward's risk or predicted his subsequent actions as he never appeared to be in crisis. However, to fully assess the risk of suicide and self-harm, information that is relevant should be discussed and shared when appropriate, in order to safeguard individuals. We make the following recommendation:

The Governor and Head of Healthcare should produce clear guidance about procedures for identifying prisoners at risk of suicide and self-harm. In particular, this should ensure that reception, healthcare, first night staff and all others who assess risk:

- **Have a clear understanding of their responsibilities and the need to share all relevant information about risk.**
- **Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide and self-harm, including information from the Person Escort Record (PER) and other sources.**
- **Document the information considered and the reasons for the decision on whether or not to open an ACCT.**

Clinical care

56. PSO 3050, *Continuity of healthcare,* states all prisoners who 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 Doward's physical healthcare was of a reasonable standard and equivalent to that which he could have expected to receive in the community, but that his mental healthcare was not equivalent.

Physical health

58. Mr Doward had a history of ischaemic heart disease and an elevated blood pressure on arrival at Manchester. His blood pressure was not checked again until the secondary healthscreen. The secondary healthscreen, which should be completed within seven days of reception, was not completed for 12 days. Manchester were unable to provide information as to why the healthscreen was late. While this did not relate directly to Mr Doward's death, timely assessments are an important contribution to ensuring any health issues are addressed.

Mental health

59. Mr Doward arrived at Manchester, which was his first time in prison, with a history of depression and he disclosed he had self-harmed four years earlier. Neither of these issues were explored further, there is no evidence the information which arrived with him (in the PER) was adequately reviewed and Mr Doward was not referred for a mental health assessment. We therefore make the following recommendation:

The Head of Healthcare should ensure that all prisoners with a history of mental ill health and/or self-harm are properly identified, reviewed and referred for a primary mental health assessment.

Emergency Response

60. 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.

61. We have previously identified failings in the management of medical emergencies at Manchester and made recommendations to ensure national guidance is followed. When Mr Doward was discovered, an officer promptly and appropriately radioed a code blue medical emergency and an ambulance was immediately requested. We are satisfied that the emergency response was in line with national guidance.

Resuscitation

62. In September 2016, The National Medical Director at NHS England, wrote to Heads of Healthcare for prisons and Immigration Removal Centres introducing new guidance to support staff on when not to perform cardiopulmonary resuscitation. This guidance was designed to address the issue of inappropriate resuscitation following a sudden death in a prison and was taken from the European Resuscitation Council Guidelines 2015 which state, “Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile.”

63. Paramedics recorded there were obvious signs of death when they assessed Mr Doward. His blood had pooled due to no circulation, he was cold to the touch and signs of rigor mortis were present - all indicators that he had been dead for some time. In interview not all the prison and nursing staff were aware of the guidance when not to perform CPR. Because not all staff were aware of the joint guidance, the appropriateness of resuscitation was not considered.

64. We understand the commendable wish to attempt and continue resuscitation until death has been formally recognised, but staff should understand that they are not required to carry out CPR in these circumstances. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased. We therefore make the following recommendation:

The Governor and Head of Healthcare should ensure that staff are given clear guidance and check their understanding about the circumstances in which resuscitation is inappropriate in accordance with European Resuscitation Council Guidelines.

65. The clinical reviewer identified other issues around the emergency response, which the healthcare provider should address.

Staff support

66. Giving staff the opportunity to collectively discuss an incident and reflect on all aspects of how it was managed is fundamental to providing the prison with feedback on any issues that need to be addressed (or indeed good practice). It also provides those directly involved with an opportunity to process events.

67. Although a debrief was held after Mr Doward's death, healthcare staff were not invited. There should have been a debrief for all staff involved in the emergency response, as set out in PSI 09/2014, *Incident Management Manual*. We make the following recommendation:

The Governor should ensure that all relevant staff, including healthcare staff, are invited to the debrief following a death in custody.

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Independent Investigations

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

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T I 020 7633 4100
F I 020 7633 4141