Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Russell Platts, a prisoner at HMP Doncaster, on 12 October 2020

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 Russell Platts died on 12 October 2020 of drug toxicity at HMP Doncaster. He was 36 years old. I offer my condolences to Mr Platts' family and friends.

Staff suspected that Mr Platts was under the influence of drugs on the afternoon of 11 October. He was being monitored under suicide and self-harm procedures at the time, so wing staff observed him twice an hour overnight, but he was not checked by healthcare staff. The next morning, staff realised Mr Platts was unresponsive. Staff tried to resuscitate him but when ambulance paramedics arrived, they declared that he was dead.

I am concerned that staff did not ask for a nurse to check on Mr Platts when they thought he was under the influence of drugs. Although a nurse later decided to withhold Mr Platts' evening medications because of suspicions he had taken illicit drugs, there is no evidence that she took physical observations or arranged to monitor him.

I am aware that Doncaster has taken steps to tackle the supply of drugs into the prison. However, this investigation has shown that more needs to be done to ensure that information about drug use is shared with the relevant staff. This would ensure that the extent of drug use across the prison is known, which can then inform the drug strategy.

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

Elizabeth Moody
Deputy Prisons and Probation Ombudsman **December 2021**

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Summary

Events

1. Mr Russell Platts was recalled to prison on 5 October 2020 and sent to HMP Doncaster.

2. Mr Platts had a history of drug misuse in the community. He tested positive for drugs when he arrived at Doncaster and staff put him on a detoxification programme.

3. On 6 October, staff suspected that Mr Platts was in possession of illicit substances. There is no evidence that any action was taken.

4. On 10 October, officers saw Mr Platts' cellmate receiving or passing items from their cell window. A subsequent cell search found mobile phone parts. Neither Mr Platts nor his cellmate accepted responsibility, so both were put on a disciplinary charge.

5. Later that day, staff started suicide and self-harm prevention procedures (known as ACCT) after Mr Platts made cuts to his arms. He told staff that he had done it out of frustration because he was being 'stitched up' for something that was not his.

6. During an ACCT check at around 5.00pm on 11 October, an officer recorded that Mr Platts appeared to be under the influence of drugs.

7. Later that evening, a nurse withheld Mr Platts' medication because of suspicions that he was under the influence. She made no record of this in Mr Platts' medical record.

8. At approximately 7.30am on 12 October, an officer carried out an ACCT check and was concerned that Mr Platts had not changed his position since her last check. She went into the cell with a colleague and realised he was unresponsive. She called a medical emergency code, and several officers and healthcare staff responded. However, neither they, nor the ambulance staff who arrived about 10 minutes later, were able to resuscitate Mr Platts, who was pronounced dead at 7.58am.

9. The post-mortem report concluded that Mr Platts died from a combination of cocaine, benzodiazepine, methadone and psychoactive substances (PS).

Findings

10. We are concerned that the officer who thought Mr Platts was under the influence of drugs on the afternoon of 11 October did not consult healthcare staff. We also note that the officer who carried out an ACCT check just before 4.00am, noted that Mr Platts was snoring. This can be a sign of a drug overdose. We consider that staff should have woken Mr Platts to check he was okay. Staff need to be reminded that snoring can be a sign of a drug overdose.

11. Despite a nurse withholding Mr Platts' evening medications because of suspicions that he might have taken illicit drugs, there is no evidence that the

nurse took Mr Platts' clinical observations or arranged to monitor him. This was a missed opportunity to check on Mr Platts' physical health and monitor for any deterioration.

12. The clinical reviewer was concerned that the reception nurse did not make a mental health referral for Mr Platts despite noting that he had ADHD and depression.

13. Neither the previous nor current Head of Healthcare responded to requests for the guidance given to staff on how to deal with suspected PS use and details of what had been done to improve things since Mr Platts' death.

14. Officers did not always complete intelligence reports when they suspected that Mr Platts was involved in taking and supplying drugs.

Recommendations

- The Governor should ensure that staff:
  - consult with healthcare staff when they suspect that a prisoner is under the influence of illicit drugs; and
  - are aware that snoring can be a sign of a drug overdose.
- The Governor should share this report with PCO Jodie Smith so she is aware of the Ombudsman's findings.
- The Head of Healthcare should ensure that where a prisoner is suspected of being under the influence of illicit drugs, staff take clinical observations and monitor them regularly.
- The Head of Healthcare should ensure that information requested by the PPO is provided promptly, in line with PSI 58/2010.
- The Head of Healthcare should review the reception screening process and ensure that staff are aware of their responsibilities to refer on to other services in line with NICE guidance NG57 and NG66.
- The Governor should ensure that staff record information about suspected drug use and submit intelligence reports where appropriate.

The Investigation Process

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

16. The investigator obtained copies of relevant extracts from Mr Platts' prison and medical records.

17. The investigator interviewed eight members of staff during November 2020. NHS England commissioned a clinical reviewer to review Mr Platts' clinical care at the prison. The investigator and clinical reviewer jointly interviewed healthcare staff and some custodial staff. All the interviews were conducted by telephone due to the COVID-19 restrictions.

18. We informed HM Coroner for Yorkshire South East of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

19. One of the Ombudsman's family liaison officers contacted Mr Platts' mother to explain the investigation and ask if she wished to raise any issues. She raised several concerns about how Mr Platts was monitored, the healthcare he received and how individuals were notified of his death. We have addressed the issues which were within the scope of our investigation in this report. Other issues have been addressed in separate correspondence.

20. Mr Platts' family received a copy of the initial report. The solicitor representing Mr Platts' mother wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

21. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out one factual inaccuracy and this report has been amended accordingly.

Background Information

HMP Doncaster

22. HMP Doncaster is a local prison, operated by Serco. It holds up to 1,145 prisoners who have been remanded in custody or sentenced. The Practice Plus Group provides clinical services.

HM Inspectorate of Prisons

23. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Doncaster in September 2019. They noted that the prison was busy and complex with a transient population. Inspectors acknowledged that much good work had been done to reduce the availability of drugs in the prison and said there was a reasonably good drugs strategy and action plan. However, they found that 61% of prisoners told them it was easy to get hold of drugs. They also found that too many prisoners did not have any meaningful activity, which they said was a dangerous combination with the ready availability of drugs.

Independent Monitoring Board

24. 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. Their latest annual report for the year to 30 September 2019 expressed concerns about the loss of experienced prison staff and too high a proportion of inexperienced staff. They were also concerned that not all the mental health needs of prisoners were being met. However, they noted positive examples of planning with community services to help prisoners on release who had high risk of drug use and other chaotic behaviours. The report found the quality of healthcare to be good and responses to emergency incidents was one of the areas of good practice they highlighted.

Previous deaths at HMP Doncaster

25. Mr Platts was the 17th prisoner to die at Doncaster since October 2018. Of the previous deaths, seven were from natural causes, eight were self-inflicted and one was drug related. We have previously made a recommendation about sharing information about suspected illicit drug use.

Assessment, Care in Custody and Teamwork (ACCT)

26. 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, Management of prisons at risk of harm to self, to others and from others (Safer Custody).

Psychoactive substances (PS)

27. PS, 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 many 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. There is emerging evidence to link PS use to endangering physical health, precipitating or exacerbating the deterioration of mental health and the risk of suicide or self-harm.

28. In July 2015, we published a Learning Lessons Bulletin about the use of PS and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for staff and prisoners to be more aware 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.

Key Events

29. On 6 December 2019, Mr Russell Platts was sentenced to two years imprisonment for assault. He was released on licence on 3 August 2020 but was recalled to prison on 5 October. He was sent to HMP Doncaster.

30. Mr Platts had a long history of substance misuse. On 5 October, a nurse carried out the first night screen. He noted that Mr Platts tested positive for amphetamines, cannabinoids, cocaine and opiates and arranged for him to be seen by a member of the substance misuse team. The nurse also noted that Mr Platts had mental health problems, including ADHD and depression, but he did not refer him to mental health services.

31. A nurse saw Mr Platts the same day for a substance misuse assessment. Mr Platts said he had been on 45 millilitres of methadone a day in the community and was prescribed atomoxetine (an ADHD medication) and sertraline (an antidepressant). The nurse decided methadone therapy should be restarted. He also put Mr Platts on an alcohol detoxification plan. He prescribed thiamine and chlordiazepoxide for alcohol withdrawal and arranged for Mr Platts to be monitored for signs of intoxication, withdrawal and/or over sedation.

32. On 6 October, a healthcare assistant tried to carry out Mr Platts' secondary health screen, but officers would not open Mr Platts' cell as they suspected he had illegal substances secreted on his person. (Staff carried out the screen on 8 October, and there were no concerns.)

33. The same day, a consultant psychiatrist noted he would not consider prescribing the ADHD medication until Mr Platts had finished his alcohol detoxification (because of the risk of taking this at the same time as illicit drugs), but his antidepressant medication could start on 13 October.

34. On 7 October, a substance misuse recovery worker met with Mr Platts. He noted Mr Platts said he had started using drugs when he was 13. He had children but there were issues with him being able to see them. He had his own scrap dealing business. Mr Platts said he felt rough at the time of the assessment and that his methadone would need increasing. The worker made three further entries on the same day, about raising Mr Platts' awareness of the dangers of drug use and about community support available (including the Sheffield community-based drugs service).

35. On 7 October, a Prison Custody Officer (PCO) saw Mr Platts for a keyworker session. Mr Platts said he did not have any concerns, felt safe at Doncaster, had family support, was waiting for his medication to be arranged and had no thoughts of self-harm or suicide. Her entry on NOMIS (electronic prison record) was made for her by another PCO two days later.

36. On 8 October, a nurse saw Mr Platts to review his medication. He said his 30ml a day methadone prescription was not keeping him stable. She discussed this with the substance misuse recovery worker, who said a five-day review was due the next day.

37. On 9 October, a PCO carried out a key worker session with Mr Platts. Mr Platts said he was having family issues and wanted someone from the Offender Management Unit to help him work on building relationships with his children. Another PCO made the NOMIS entry for this officer as the officer's NOMIS security access was being routinely updated.

38. On 10 October, staff saw Mr Platts' cellmate receiving or passing items from his cell window when prisoners were exercising in the yard. A cell search revealed several mobile phone components which neither Mr Platts nor his cellmate accepted responsibility for, so both were put on a disciplinary charge. The cellmate told an officer that he felt unsafe remaining in a cell with Mr Platts, so he was moved to another cell.

39. On the evening of 10 October, a PCO started suicide and self-harm prevention procedures (known as ACCT) because Mr Platts had made superficial cuts to his arms. Mr Platts said he was frustrated but not suicidal. Staff put him on two observations an hour.

40. In the early hours of 11 October, Mr Platts gave the PCO a note saying he was 'sick of people selling shit on the wing' and that he wanted to clean up, talk to someone and 'give names'. The note said the phone found in his cell was not his.

41. Later that morning, at the ACCT assessment interview (carried out by a PCO), Mr Platts said he had had enough and that he was being 'stitched up' for something that was not his. He said he had made cuts to his arms as a stress release and not to try to end his life. He said he had not self-harmed before but had tried to hang himself in July. Mr Platts said he was very depressed, was not sleeping well and was struggling to keep food down. He said that he had not received his ADHD medication or sertraline.

42. A Custodial Operations Manager (COM) chaired the first ACCT review. A member of healthcare staff was present. The COM noted that Mr Platts was tearful and 'out of normal character'. Mr Platts said he did not want to be alive anymore but also said he wanted to be there for his children. He said he had a legitimate business in the community and would be out of prison very soon.

43. A mental health nurse talked to Mr Platts about the fact he had not been receiving antidepressant medication, and that Mr Platts felt his mood was fluctuating. The nurse noted he would speak to the psychiatrist about Mr Platts' medication and that he agreed Mr Platts should stay on the ACCT.

44. The COM noted that the ACCT was to remain open on two observations an hour and three quality interactions. He also phoned the wing (he does not remember who he spoke to) and asked them to ensure Mr Platts shared a cell with someone, but this was not arranged before his death. He set the next review for 14 October.

45. On 11 October, a member of staff completed an intelligence report recording that at about 2.30pm, Mr Platts had threatened to snap his ex-cellmate's neck. He was also abusive to another prisoner, when demanding a vape. The officer noted that they had recorded the incident in the wing observation book. They assigned a security threat level of 'low' and noted in 'supporting evidence' that on

10 October, Mr Platts had tried to bribe/corrupt staff and various mobile phone components had been found in his cell. On 9 October Mr Platts had given information about a phone held by another prisoner.

46. At 5.00pm PCO A noted on the ACCT observations sheet that Mr Platts appeared to be under the influence of drugs. Over the next few hours Mr Platts was either asleep or sitting on his bed.

47. A nurse did not give Mr Platts his medication because of concerns he was under the influence. She did not note these concerns in the SystmOne record or do anything further.

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48. At 3.54am, a PCO noted that Mr Platts was lying on his side snoring during the ACCT check. All subsequent entries say he was asleep. At 6.05am, another PCO took over observations and completed the required checks. On each occasion she noted that Mr Platts was asleep.

49. At 7.32am, the PCO checked on Mr Platts, and was concerned because she was not sure if Mr Platts had moved since her last check. She told a colleague. The officers looked through the observation panel and went into the cell.

50. Mr Platts was lying on his side, but the officers realised his head was turned into his pillow. They had not been able to tell this from looking through the observation flap in the dim light and had assumed his head had also been on its side. He had no pulse, and his face was discoloured. At 7.43am, a PCO called a code blue (a medical emergency code indicating that a prisoner is not breathing or is having breathing difficulties) and other staff arrived, moving Mr Platts outside the cell so there was more room to work. A PCO started cardiopulmonary resuscitation (CPR) and staff in the control room called the ambulance in response to the code blue.

51. A nurse and a healthcare assistant also responded to the code blue. The healthcare assistant arrived first and applied an Automated Electronic Defibrillator which recommended ‘no shock’. The nurse told the investigator and clinical reviewer that she was unable to insert an airway because Mr Platts’ jaw was clenched and there was blood in his throat and nostrils which could not be removed by suction. She said that Mr Platts was still warm to the touch and she was satisfied that he did not have rigor mortis (stiffening of the body after death) as only his jaw was clenched.

52. At 7.53am paramedics arrived, and at 7.58am they pronounced that Mr Platts was dead.

Contact with Mr Platts’ family

53. On 12 October, the prison appointed a prison manager as the family liaison officer (FLO). She visited the family that morning to break the news. They had already been informed by someone else who had been told by a prisoner.

54. Doncaster contributed to the costs of Mr Platts’ funeral in line with national policy.

Support for prisoners and staff

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

56. The prison posted notices informing other prisoners of Mr Platt's death, and offering support. We understand that the notices initially incorrectly gave the date of death as occurring on 10 October, but that this was rectified. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Platt's death.

Post-mortem report

57. The post-mortem examination found no obvious physical cause of death. Toxicology tests showed evidence of cocaine and benzodiazepine misuse, and the level of methadone was on the boundary between toxic and therapeutic levels. There was also evidence of PS use prior to death. The pathologist noted that PS is linked to sudden deaths. The pathologist concluded that Mr Platt's death was caused by the combination of drugs he had taken before he died. Chronic drug misuse had also contributed to but not caused the death.

Findings

58. Mr Platts died as a result of using a combination of drugs, most of which he had not been prescribed. This obviously placed him at risk. Although it was his choice to take the drugs, we have considered whether there is anything that prison or healthcare staff might have done to reduce his risk.

Management of Mr Platts while under the influence of drugs

59. We are concerned that PCO A did not consult with healthcare staff when she thought that Mr Platts was under the influence of drugs at around 5.00pm on 11 October. When interviewed, she said that Mr Platts was drowsy, but she was not sure whether this was the effects of his afternoon medication or whether he was under the influence. When asked what procedures staff should follow when they suspect a prisoner might be under the influence, she was unsure.

60. We consider that staff should always ask for healthcare staff to check on prisoners who may have taken illicit drugs. They will be able to assess whether a prisoner needs emergency care or whether they need to be monitored for any deterioration. Mr Platts was not checked or monitored by healthcare staff from when he was suspected of being under the influence at 5.00pm on 11 October to when he was found unresponsive at around 7.30am the next day.

61. At 3.54am on 12 October, a PCO (who has since resigned from SERCO) noted that Mr Platts was lying on his side snoring. We see many drug-related deaths where snoring has been noted as a sign that the individual is alive and 'sleeping it off', when in fact it can be a recognised sign of respiratory distress caused by a drug overdose. Prison staff should be aware that snoring can be a sign of a drug overdose and if a prisoner who is suspected of being under the influence is heard snoring, they should be woken and checked.

62. We make the following recommendations:

The Governor should ensure that staff:

- **consult with healthcare staff when they suspect that a prisoner is under the influence of illicit drugs; and**
- **are aware that snoring can be a sign of a drug overdose.**

The Governor should share this report with PCO A so she is aware of the Ombudsman's findings.

Clinical care

63. The clinical reviewer concluded that overall, the clinical care given to Mr Platts was equivalent to that he could have expected to receive in the community. He noted that Mr Platts engaged well with the Substance Misuse Service, received ongoing monitoring for drug withdrawal and his methadone was kept under review. However, the clinical reviewer found some shortcomings.

Withholding of medication on the evening of 11 October

64. On 11 October, the evening before Mr Platts' death, a nurse did not give Mr Platts his evening medication because staff suspected he had taken illicit drugs. The investigator and the clinical reviewer learned this from the healthcare provider's own 72-hour review into Mr Platts' death.

65. Although this was an appropriate decision because of the risks of mixing prescription and illicit drugs, the nurse made no entry in Mr Platts' SystmOne record and there is no evidence that she took any physical observations, monitored him or shared the information at a handover (or otherwise).

66. The investigator asked the Head of Healthcare if there was guidance to staff on what they should do if a prisoner was suspected of using PS. The investigator also asked what had been done since Mr Platts' death. The Head of Healthcare left her position at Doncaster without responding. The investigator asked the same questions of the new Head of Healthcare, who also did not respond.

67. The investigator asked the substance misuse recovery worker who sometimes assists with the medication rounds what action staff should take if they withhold medication because of suspected PS use. He said observations should be taken straightaway and the prisoner should be checked three times a day by healthcare staff regardless of what other checks may be in place (such as ACCT checks).

68. We make the following recommendations:

    The Head of Healthcare should ensure that where a prisoner is suspected of being under the influence of illicit drugs, staff take clinical observations and monitor them regularly.

    The Head of Healthcare should ensure that information requested by the PPO is provided promptly, in line with PSI 58/2010.

Mental health

69. The clinical reviewer was concerned that although a nurse noted that Mr Platts had mental health problems, including ADHD and depression, during the reception screen, he did not make a mental health referral as he should have done. We make the following recommendation:

    The Head of Healthcare should review the reception screening process and ensure that staff are aware of their responsibilities to refer on to other services in line with NICE guidance NG57 and NG66.

70. The clinical reviewer considered that once the appropriate services were made aware of Mr Platts, mental health care was responsive. Mr Platts' psychotropic medication for his ADHD was appropriately reviewed by a psychiatrist with plans to reintroduce the medication when appropriate, and when an ACCT was opened mental health staff supported it.

Illicit drug availability at Doncaster

71. The most recent HMIP report in 2019 commented on the easy availability of drugs at Doncaster and the dangerous combination of that with a lack of meaningful activity for prisoners, a factor likely to have been made worse by the COVID-19 pandemic and loss of normal activities in the prison.

Local drugs strategy

72. In March 2019, Doncaster created a new role of Drugs Strategy Manager. The HMPPS National Drug Strategy was published in April 2019, providing detailed guidance for prisons to help them identify issues and share best practice. In line with this, Doncaster's Substance Misuse Strategy was revised in July 2019. We were told it is reviewed annually, the last time before Mr Platts' death being June 2020.

73. At interview, as part of another Doncaster investigation, the Drugs Strategy Manager said that there is a monthly drugs strategy meeting held at the prison, which has representation from across the prison as well as representation from community services. These meetings, which have continued throughout the COVID-19 pandemic, focus on restricting supply, reducing demand and building recovery. At interview, the Security Manager said there are now additional enhancements to the drugs strategy to reduce supply. These include placing all prisoners coming into prison on licence recalls into prison issue clothing and subjecting all their clothing and possessions to checks by a drugs dog and the Rapiscan machine (a special device for detecting drugs).

74. Doncaster continues to make efforts to challenge the availability and demand of PS. In an update from Doncaster in July 2021, we were told that the prison has bolstered their fight against illicit substances getting into the prison through the following measures:

- Since the beginning of February 2021, a body scanner has been in place in reception which helps to prevent prisoners bringing drugs into the prison.
- Additional personnel have been added to the Dedicated Search Team (DST).
- Additional resources have been added to the Security team to manage corruption.
- There have been increased drug operations with external police support.
- A reconfiguration of residential areas will enable a drug stabilisation and rehabilitation unit to be established.
- The drugs strategy has been revised with a renewed emphasis to address key issues and risks within Doncaster.

75. Mr Platts died during a challenging period for staff during the COVID-19 pandemic, which also meant it was not possible to conduct the normal drug tests on prisoners. But it is a concern that Mr Platts was able to obtain a range of illicit drugs, including PS.

76. In the light of the ongoing work, we do not make a recommendation about reducing the drug supply at Doncaster, although the Director will clearly need to ensure that the momentum and focus continue.

Sharing of information about drug use

77. We are concerned that information about Mr Platts' drug use was not always appropriately shared or acted upon by healthcare or custodial staff.

78. On 6 October, staff suspected that Mr Platts had brought illegal substances into the prison. There is no evidence that the officers completed an intelligence report or took further action.

79. On 10 October, staff searched Mr Platts' and his cellmate's cell and found several mobile phone components. Staff did not submit an intelligence report about the incident (although this matter is referred to in another intelligence report submitted the next day about something else). The investigator asked a PCO about the lack of a report, and she said she would usually fill one in but was not sure if she had on this occasion.

80. We are concerned that staff did not report information about suspected drug use and suspected involvement in drug supply. We recommend:

The Governor should ensure that staff record information about suspected drug use and submit intelligence reports where appropriate.

Informing prisoners of Mr Platts' death

81. Mr Platts' mother said that she was told by another prisoner that prisoners were informed of Mr Platt's death on 10 October (that is, two days before the prison told her that her son had died). We are satisfied that there is abundant evidence that Mr Platts died on 12 October. We understand that the prison issued notices to prisoners saying, incorrectly, that Mr Platt had died on 10 October and that this was corrected when the error was spotted. We are satisfied that these notices were not issued on 10 October and that the prisoner who told Mr Platts' mother that they had been, was mistaken. It is very unfortunate that the prison's error and misinformation from a prisoner has caused Mr Platts' mother additional distress.

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