Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Colin Mitchell, a prisoner at HMP Leeds, on 18 November 2020

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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 Colin Mitchell was found hanged in his cell at HMP Leeds on 18 November 2020. He was 71 years old. I offer my condolences to Mr Mitchell's family and friends.

Mr Mitchell's trial for alleged sexual offences started on 16 November and he was due to appear in court again on the day he was found hanged. The investigation found that when Mr Mitchell returned from court on 16 and 17 November, he was not screened as he should have been to check for any potential risk of suicide and self-harm.

My investigation also found that staff did not properly assess Mr Mitchell's risk of suicide and self-harm when he had arrived at Leeds and that they therefore missed an opportunity to identify that the start of Mr Mitchell's trial might increase his risk of suicide.

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 **June 2021**

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Summary

Events

1. On 25 February 2020, Mr Colin Mitchell was remanded in prison custody, charged with sexual offences, and sent to HMP Leeds.

2. Mr Mitchell arrived with a suicide and self-harm warning (SASH) form but reception staff assessed that suicide prevention measures (known as ACCT) were not necessary.

3. Mr Mitchell's trial started on 16 November and he appeared in court on 16 and 17 November. When he returned to his cell on 17 November, he discovered his cellmate had been transferred to another prison.

4. On 18 November, at around 7.07am, an officer arrived at Mr Mitchell's cell to unlock him for his court appearance. The officer could not get a response from Mr Mitchell, entered the cell and found him hanging from the window behind his privacy curtain. The officer shouted for assistance and radioed a medical emergency code. Staff did not try to resuscitate Mr Mitchell as it was clear he was dead. Paramedics attended and at 7.25am, confirmed that Mr Mitchell had died.

Findings

5. We found that reception staff did not properly assess Mr Mitchell's risk of suicide and self-harm when he arrived at Leeds. They also failed to record that Mr Mitchell had had recent suicidal thoughts.

6. As a result, when his trial started in November, this information was not considered in the context of a potential trigger or increase in his risk.

7. Prisoners who leave prison to attend court should be screened when they return to identify those who may be at risk of suicide and self-harm. We found no evidence that Mr Mitchell was screened when he returned from court on 16 and 17 November.

8. We found that the support and engagement by Mr Mitchell's original key worker was an example of best practice. However, his subsequent key worker, who was allocated at the start of September, was unable to meet with Mr Mitchell before he died. This was a missed opportunity to provide support to Mr Mitchell, particularly at the start of his trial.

Recommendations

- The Governor and Head of Healthcare should ensure that reception staff:
    - consider all information arriving with the prisoner, particularly the PER and SASH form, when assessing their risk of suicide and self-harm;
    - start ACCT procedures whenever a prisoner has significant risk factors, regardless of the prisoner's stated intentions; and

- record the information considered and their reasoning when they decide not to start ACCT procedures.

- The Governor and Head of Healthcare should ensure that:
  - prisoners' potential triggers for suicide and self-harm, such as court dates, are identified and flagged to relevant staff; and
  - following court appearances, prisoners are assessed for their risk of suicide and self-harm and any potential health issues.

- The Governor should ensure that vulnerable prisoners are identified and prioritised for key work and that key workers are given time to meet regularly with the prisoners allocated to them.

- The Governor should share this report with the officer to ensure she is aware of the Ombudsman's comments about her good practice.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Leeds, informing them of the investigation and asking anyone with relevant information to contact her. Nobody responded.

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

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

12. The investigator accompanied by the clinical reviewer, interviewed six members of staff at Leeds on 9 December and the healthcare manager on 14 December. All interviews were conducted by video or telephone due to the COVID- 19 restrictions. One prisoner declined to be interviewed.

13. We informed HM Coroner for Yorkshire West of the investigation. The coroner provided us with a copy of the post-mortem report. We have sent the coroner a copy of this report.

14. The Ombudsman's family liaison officer, wrote to Mr Mitchell's brother in December 2020, to explain the investigation. Mr Mitchell's brother did not have any questions.

15. The prison received a copy of the report and did not identify any factual inaccuracies. An action plan for the recommendations is annexed to the report.

Background Information

HMP Leeds

16. HMP Leeds is a local prison which can hold a maximum of 1,218 prisoners who are on remand, convicted or sentenced. The prison serves the courts of West Yorkshire. Practice Plus Group (previously known as Care UK) provides healthcare services, including mental health services. The prison has 24-hour primary healthcare cover.

HM Inspectorate of Prisons

17. The most recent full inspection of HMP Leeds was in November/December 2019. Inspectors found that the need for mental health support was high, with 61% of respondents to the HMIP survey saying that they had a mental health problem. A mental health awareness training package had been developed for prison staff but, at the time of the inspection, only 63 staff had received it. Inspectors recommended that prison managers and healthcare commissioners should ensure there were sufficient mental health resources to meet unmet need.

18. Inspectors found the levels of self-harm were significantly higher than at other local prisons and since their last inspection. They noted that ACCT case management was not good enough despite PPO recommendations, and that the safeguarding strategy was not effective in addressing risks or the needs of individuals in crisis.

19. Inspectors found key working was developing well. All prisoners had a key worker, and staff and prisoners were reasonably positive about its value.

20. HMIP carried out a short scrutiny visit to Leeds in June 2020 (along with two other local prisons) to assess how well they had responded to the COVID-19 pandemic. Inspectors reported that Leeds was calm and well-ordered, despite the severe restrictions on the regime. Leeds had experienced a significant outbreak of the virus but had effectively controlled it. Prisoners reported being kept well informed. Inspectors noted that the key worker scheme at Leeds during the pandemic was targeted at those prisoners who had been identified as most vulnerable.

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 annual report for the year ending December 2018, the IMB reported that prisoners were treated with humanity and respect despite current staff constraints. However, the Board was concerned about high levels of violence at Leeds.

Previous deaths at HMP Leeds

22. Mr Mitchell was the 21st prisoner to die at Leeds since November 2018. Of the previous deaths, seven were self-inflicted, 11 were from natural causes, one was

drug-related, and one is awaiting classification. There has been another self-inflicted death since.

23. We have previously made recommendations to Leeds about reception screening for suicide and self-harm risk, screening following court appearances and the management of the key worker scheme.

Assessment, Care in Custody and Teamwork

24. 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 support the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody).

25. 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, multidisciplinary review meetings involving the prisoner. As part of the process, a caremap (a 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.

Key worker scheme

26. HMPPS's policy document, *Managing the Custodial Sentence Policy Framework*, set out the minimum requirements needed to case manage those in custody from reception to the end of post-release supervision. This included the gradual introduction of the key worker role from September 2018, replacing the previous system of personal officers. Requirements of the scheme include:

- All prisoners in the male closed estate must be allocated to a key worker whose responsibility is to engage, motivate and support them throughout the custodial period.
- All prison officers who work on a residential unit will be allocated a maximum of six prisoners. Governors must ensure that time is made available for an average of 45 minutes per prisoner per week for delivery of the key worker role, which includes individual time with each prisoner.
- Key workers will record meetings, discussions and any progress that has been made on NOMIS in a detailed manner. These notes will be regularly checked as part of on-going quality assurance, so it is important that they are sufficient.

Key Events

27. On 25 February 2020, Mr Colin Mitchell was remanded in custody charged with sexual offences and sent to HMP Leeds. It was his first time in prison.

28. Mr Mitchell's 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) noted, 'Set off to jump from Malham Cove (24.02.20)' (the police had arrested Mr Mitchell at a local beauty spot where he was contemplating suicide) and the medical section said that Mr Mitchell had suicidal thoughts. The PER was accompanied by a Suicide and Self-Harm Warning (SASH) form (also referred to by the form number, BD007) which had been completed by court staff.

29. An officer completed Mr Mitchell's reception screen, although Operational Support Grade made the entry on Mr Mitchell's prison record. The entry says that Mr Mitchell arrived with a SASH form but he said he was fine and had no thoughts of suicide or self-harm. Staff did not start suicide and self-harm prevention measures (known as ACCT).

30. A nurse carried out Mr Mitchell's initial health screen. She recorded that Mr Mitchell had no physical or mental health issues, was not prescribed any medication and that he had no thoughts of suicide or self-harm. The nurse did not record the information about his recent suicidal thoughts and did not refer him to the mental health team for assessment. Mr Mitchell was moved to F Wing, the vulnerable prisoner unit.

31. On 3 March, an officer introduced herself to Mr Mitchell as his key worker. Key workers 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. She met with Mr Mitchell regularly, at least weekly, and made 36 comprehensive entries in his prison record.

32. The Key Worker told the investigator that Mr Mitchell was always polite and while he did not want to engage when they first met, he was always pleased to see her and used to chat with her as time went on. She said Mr Mitchell was 'a little anxious' about his trial, but that he did not seem particularly stressed.

33. The Key Worker recorded that Mr Mitchell moved cells in July, as he was not getting on with his cellmate. She said the friction arose because Mr Mitchell would put the television on late at night. She said that situations like this were not unusual given the amount of time prisoners were spending locked up together because of the COVID-19 restrictions. The Key worker said she was reassured by Mr Mitchell that he had not been threatened or bullied.

34. Due to his age, Mr Mitchell was in a high-risk group if he contracted the COVID-19 virus. Initially he self-isolated, but on 20 July, he decided that he no longer wanted to shield and signed a disclaimer to that effect.

35. On 24 August, the Key worker recorded that she had met with Mr Mitchell and he told her that his court case had been adjourned because of the COVID-19 pandemic, but that he accepted the situation and appeared in good spirits. This

was the last time the key worker had contact with Mr Mitchell as she had an accident which meant she was put on restricted duties.

36. A new officer was allocated as Mr Mitchell's new key worker. However, he did not meet with Mr Mitchell as he worked night shifts during the time between being assigned as Mr Mitchell's key worker and when he died, so did not have the opportunity to introduce himself.

37. In the early hours of 6 October, an officer answered Mr Mitchell's emergency cell bell. Mr Mitchell had a cut above his right eye and said that he had been assaulted by his cellmate because he had turned the television on. A nurse attended and dressed the wound with steri-strips. The custodial manager spoke to Mr Mitchell's cellmate, who admitted the assault. Officers moved Mr Mitchell to another cell which he occupied on his own until 13 October, when a cellmate was moved into the cell with him.

38. An officer completed an incident reporting form and placed Mr Mitchell's cellmate on a disciplinary charge for assault. The forms were sent to the Orderly Officer, the operational manager of the prison. However, because the information did not reach the correct department, a disciplinary hearing was not held and Mr Mitchell's cellmate was not punished. The Officer also completed a Challenge, Support and Intervention Plan (CSIP – violence reduction measures) for Mr Mitchell.

39. On 9 October, a supervising officer from the Safer Custody Team interviewed Mr Mitchell as part of the CSIP process. Mr Mitchell had already been moved to another cell and he raised no concerns, so the supervising officer assessed that no additional support or further action was necessary and closed the CSIP.

40. On 9 November, an officer recorded that Mr Mitchell had appeared in court by video link and that he had been remanded; no other details are recorded. This was the last entry on Mr Mitchell's prison record before he died.

41. Mr Mitchell attended court on 16 and 17 November for the start of his trial. The PER that accompanies a prisoner to court is completed overnight by healthcare staff. A Nurse completed both PER forms for Mr Mitchell's court appearances and no risk of suicide or self-harm was noted.

42. A nurse saw Mr Mitchell each morning before he attended court and assessed him as fit to attend. They checked his physical observations and noted that he said he had no thoughts of suicide or self-harm. There is no evidence that Mr Mitchell was reviewed by prison or healthcare staff when he returned from court on either occasion.

43. Mr Mitchell's cellmate, said that when Mr Mitchell returned from court on 16 November, he was tired and went to bed early, but he thought he was awake during the night watching television. The next morning, when Mr Mitchell was woken for court, he said he was confused, worried and tired. The cellmate was moved out of Leeds that day so did not see Mr Mitchell again. He said that Mr Mitchell had never mentioned feeling suicidal.

44. On 17 November, Mr Mitchell attended court and returned to F Wing at 6.19pm. He spoke to an officer and was locked in his cell. Mr Mitchell and the prisoner next

door both activated their cell bells around 6.22pm. The officer went to Mr Mitchell's cell at 6.29pm and had a brief conversation with him through the observation panel about his canteen sheet, before leaving. In his prison statement the officer said Mr Mitchell did not appear to be low in mood, was his usual self and did not raise any other concerns. CCTV shows OSG an officer completed the roll check (count of prisoners) at 8.42pm.

Wednesday 18 November

45. CCTV shows an officer the night patrol officer, completed the early morning roll check at 5.35am. He opened the observation panel on Mr Mitchell's cell, used a torch to check the cell and moved on. The officer said in his statement that he saw what he believed to be someone in bed and did not see anything suspicious.

46. An officer started his shift around 7.00am and shortly afterwards he started to unlock prisoners due in court. At 7.07am, the officer reached Mr Mitchell's cell. He looked through the observation panel and opened the door. The officer called Mr Mitchell's name, but got no response. He entered the cell and in order to rouse Mr Mitchell went to shake his leg but discovered there were just blankets under his cover. The officer discovered Mr Mitchell suspended by a torn bedsheet attached to the window, behind his privacy curtain; Mr Mitchell had placed furniture in front of the curtain to obscure the view of his legs. The officer immediately left the cell, radioed a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties) and shouted for staff to assist.

47. An officer was close to the cell and responded immediately, along with two more officers. An officer entered the cell, used his anti-ligature knife to cut the ligature and lowered Mr Mitchell to the floor. The other two officers activated their body-worn video cameras (BWVC) and assisted their colleague. They did not start cardiopulmonary resuscitation (CPR) as it was evident Mr Mitchell was dead: he was cold, stiff and his blood had started to pool, all signs he had been dead for some time. A short time later a nurse responded to the code blue. She examined Mr Mitchell and agreed that they should not start CPR.

48. North West Ambulance Service records show that they received a request for an emergency ambulance at 7.09am. Paramedics arrived at Mr Mitchell's cell around 7.21am and confirmed his death at 7.25am.

After Mr Mitchell's death

49. A prisoner told a prison manager, that around 10.00pm on 17 November, Mr Mitchell was banging on his cell door saying that his cellmate had stolen some of his belongings. However, other prisoners in the cells next to Mr Mitchell said they did not hear any banging. There is nothing recorded in the wing observation book or in Mr Mitchell's prison record. In relation to the allegation of theft, West Yorkshire Police obtained a copy of the property the cellmate arrived with at his next prison, HMP Doncaster. There was nothing identifiable that belonged to Mr Mitchell and no further action was taken.

Contact with Mr Mitchell's family

50. Leeds appointed a supervising officer as the family liaison officer (FLO). While under normal circumstances next of kin should, wherever possible, be informed of a death in person by a FLO, Government advice at the time prohibited all but essential travel and required social distancing to prevent the spread of the COVID-19 virus. With the assistance of West Yorkshire Police, Mr Mitchell's brother's address details were obtained, and he was informed of the death. The family liaison officer offered his condolences and ongoing support. In line with Prison Service instructions, the prison contributed towards the costs of Mr Mitchell's funeral, which was held on 14 December.

Support for prisoners and staff

51. A prison manager debriefed most of the staff involved in the emergency response. Those that did not attend the debrief said they knew how to access support if they needed to. Healthcare staff were also supported by the healthcare provider.

52. The prison posted notices informing other prisoners of Mr Mitchell'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 Mitchell's death.

Post-mortem report

53. The post-mortem report concluded that Mr Mitchell died from hanging.

Findings

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

Reception

54. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)* sets out the procedures (known as ACCT) that staff should follow if they identify that a prisoner is at risk of suicide and self-harm. It also lists potential risk factors and triggers for suicide and self-harm. Mr Mitchell arrived at Leeds on 25 February with a number of risk factors: it was his first time in prison, he had contemplated suicide before his arrest, he had been charged with serious offences, and he faced a lengthy sentence if convicted.

55. PSI 07/2015 *Early Days in Custody* states that the PER and any other available information must be examined by reception staff and the prisoner must be interviewed to assess their risk of suicide and self-harm. Mr Mitchell arrived with a BD007 Suicide and Self-Harm Warning (SASH) form which said he had contemplated suicide just before he was arrested. Despite being interviewed by prison and healthcare staff, this information was not accurately recorded in either Mr Mitchell's prison or healthcare record. Staff did not assess him as being at risk of suicide or self-harm and did not start ACCT procedures.

56. While we accept that Mr Mitchell did not take his life until almost nine months later, we are concerned that this case highlights failings in the reception screening procedures at Leeds.

57. An officer said he did not recall the reception screening interview with Mr Mitchell but told the investigator that OSG entry on Mr Mitchell's prison record was based on information he had provided. The investigator spoke to the supervising officer who explained that there were only two computer terminals in reception for prison staff and that experienced officers therefore interviewed the prisoners arriving, while OSG colleagues entered the information onto the prison record.

58. A nurse said she did not recall the initial health screen in detail, although she said it was late at night, it had been a very long day and Mr Mitchell was tired. The nurse said the PER and SASH forms were usually available to healthcare staff and she was unable to say why she did not record the information contained on the SASH form or refer Mr Mitchell for a mental health assessment.

59. An Acting Head of Healthcare said that documents like the PER and SASH forms are not always available to reception nurses and he had arranged a review to identify how frequently this happens. The Acting Head of Healthcare also said he would be submitting a business case to NHS England for an extra nurse in the prison's very busy reception to ensure nurses have adequate time to review each prisoner and their records.

60. 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 place too much weight on staff's perception of the prisoner and they do 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. All risk factors must be collated and considered to ensure that a prisoner's level of risk is judged holistically.

61. The Head of Safety told us that Leeds had developed a new 'Risk of Suicide Identification Form' to help reception staff to identify the factors that may increase risk and support the decision of whether or not to start ACCT procedures.

62. We recommend:

The Governor and Head of Healthcare should ensure that reception staff:

- **consider all information arriving with the prisoner, particularly the PER and SASH form, when assessing their risk of suicide and self-harm;**
- **start ACCT procedures whenever a prisoner has significant risk factors, regardless of the prisoner's stated intentions; and**
- **record the information considered and their reasoning when they decide not to start ACCT procedures.**

Court appearance

63. PSI 64/2011 lists the start of a trial as a potential trigger for suicide and self-harm. We note that it was nearly nine months between when Mr Mitchell arrived at Leeds and his death. However, because the information had not been recorded from the SASH form when he arrived at Leeds in February, nobody was aware of his history of suicidal thoughts and this was missing from the PER form.

64. Prison Service Order (PSO) 3050, *Continuity of healthcare for prisoners*, says that events, such as a court appearance, that require a prisoner to leave the prison and pass back through prison reception, can have a significant impact on the health of a prisoner. For those prisoners passing through reception, prisons are required to have protocols in place for screening them to identify any potential healthcare or suicide and self-harm issues. There is no record this was done when Mr Mitchell returned from court on 16 and 17 November.

65. The head of safety and the health care manager told the investigator that they were revising the arrangements for reviewing prisoners returning from court. The protocol in place at the time of Mr Mitchell's death was that prisoners sentenced to over 10 years would be referred to mental health for review, but there was no arrangement for routine review or assessment.

66. The head of safety said Leeds had recognised that a prisoner's risk could change after a court appearance, whether that is at the start of a trial or after sentencing, or following a solicitor's visit and that staff should not rely on a prisoner's presentation. He said that following the last two deaths by suicide at Leeds, where both prisoners had recently appeared in court, staff were now doing a wellbeing check of every prisoner.

67. The head of safety said that key dates, such as trials and sentencing, and the nature of certain offences that might increase risk, were now flagged as part of the weekly Safety Intervention Meetings (SIM) and he expected this information to be shared with relevant departments, including healthcare. Since 25 January, a daily report of all prisoners on this list with the key dates has been sent to all managers.

68. The head of safety provided some context about the pressures faced at Leeds around the time of Mr Mitchell's death: he said that during October and November 2020 around 120-150 staff were absent from the prison because they had either tested positive for COVID-19 or were isolating. The head of safety said he was confident that despite the challenges faced, the revisions in the process for identifying prisoners at possible increased risk of suicide or self-harm could be implemented but would be reviewed.

69. We acknowledge the significant difficulties Leeds faced due to the COVID-19 pandemic, and that the prison has already identified issues and responded by reviewing and revising processes. Nevertheless, we recommend:

The Governor and Head of Healthcare should ensure that:

- **prisoners' potential triggers for suicide and self-harm, such as court dates, are identified and flagged to relevant staff; and**
- **following court appearances, prisoners are assessed for their risk of suicide and self-harm and any potential health issues.**

Clinical care

70. The clinical reviewer concluded that Mr Mitchell's clinical care was not equivalent to that which he could have expected to receive in the community.

71. The investigation identified there was a significant oversight by the nurse in not recording information that arrived with Mr Mitchell. She did not record that he had actively considered suicide the day before he arrived at Leeds and she did not refer Mr Mitchell for a mental health assessment. Because this information was not recorded in the medical record, when the PER forms were completed at the start of his trial in November, there was no record that his risk may increase.

72. The clinical reviewer asked one of the health care m to complete an investigation into the actions of the nurse, which he agreed to do. We do not therefore make a recommendation.

Key worker scheme

73. Key work was formally suspended across the prison estate on 24 March 2020 due to the COVID-19 pandemic. On 12 May, the Prison Service issued an Exceptional Delivery Model (EDM) for key work. This provided a framework of principles within which establishments must operate but left it to individual prisons to decide how to deliver key work safely during the pandemic. The EDM recommended that key work should continue for certain identified priority prisoner groups, including those prisoners at risk of suicide or self-harm and those who were clinically extremely vulnerable to COVID-19 and had been advised to shield.

74. Mr Mitchell was in a high-risk group for COVID-19 and shielded up to 20 July, when he decided that he no longer wanted to shield. His key worker saw him regularly during this time. Her detailed entries in his prison record are an example of best practice and show how she established a rapport with him, recognising that he was socially isolated. (During his time at Leeds, Mr Mitchell wrote a couple of letters to his brother but did not have any visits and did not make any telephone calls.) However, although a new key worker was allocated at the start of September, he did not meet with Mr Mitchell before he died.

75. We acknowledge the significant pressures faced at Leeds around the time of Mr Mitchell's death because of low staff numbers. However, we consider that more attention should have been given to supporting those prisoners who may be experiencing isolation due to a lack of social contact, especially at significant points in their prison time, such as the start of a trial.

76. The Head of safety said that the Operations Group have now been tasked with identifying prisoners on the SIM briefing who have not made a telephone call or received a visit for 28 days and may be socially isolated. This new process will need to be fully understood and be reviewed to ensure it is effective. We recommend:

The Governor should ensure that vulnerable prisoners are identified and prioritised for key work and that key workers are given time to meet regularly with the prisoners allocated to them.

The Governor should share this report with the officer to ensure she is aware of the Ombudsman's comments about her good practice.

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