

**Investigation into the circumstances surrounding the
death of a prisoner at HMP Camp Hill**

**Report by the Prisons and Probation Ombudsman for
England and Wales**

January 2008

This is the report of an investigation into the death of a man who was found hanging in his cell at HMP Camp Hill.

I would like to offer my own and my colleagues' condolences to the man's wife, family and friends. I know that he came from a close knit family and that he will be sadly missed. I hope that my report addresses all the family's concerns.

The investigation was carried out on my behalf by one of my investigators. A clinical review was conducted by the Isle of Wight Primary Care Trust. I am most grateful to the Governor and his staff for their co-operation and assistance with my investigation.

This is the first apparently self inflicted death to have occurred at HMP Camp Hill since September 2003 and the first since my office began investigating deaths in custody. My investigation highlights a number of lessons to be learnt with regard to the prison's procedures when handling deaths in custody. I make six recommendations.

It is evident that the man who is the subject of this investigation suffered considerably from ill health and had for some time been in great pain. He also had a history of mental health problems and had attempted to take his life on a number of occasions. I believe that many of these issues could be addressed in more depth than has been done so far in the Isle of Wight Primary Care Trust's report. One of my recommendations, therefore, is that a further review of the clinical care afforded to the man should be undertaken.

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

Stephen Shaw CBE
Prisons and Probation Ombudsman

January 2008

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SUMMARY

The man who is the subject of this investigation had a well documented history of self harm and had on several occasions attempted to take his own life. In 2003, the man made three attempts on his life before being sectioned under the Mental Health Act.

In July 2005, the man was remanded in custody to HMP Winchester. In September that year he was found hanging in his cell and later that month made a number of cuts to his arms. In response to his actions and in order to observe, assess and support the man, staff opened an Assessment, Care in Custody and Teamwork (ACCT) booklet. This was closed a month later. In October 2005, he was sentenced to five years' imprisonment.

On 7 November, the man was transferred to HMP Camp Hill. That evening he was admitted to hospital with acute abdominal pains and was subsequently transferred to HMP Parkhurst's healthcare centre. In December, staff opened another ACCT on him. In January 2006, he was found in possession of a ligature.

The man transferred back to Camp Hill in June 2006. In August, he complained to staff that he was being bullied for his medication. In September, his mother died. As a consequence of these events he was again placed on an ACCT.

The man was admitted to hospital in October for surgery, during which he was fitted with a catheter. Over the following months he complained to staff on a number of occasions about the pain he was experiencing, often during the night. Because of his health problems he was given access to additional showers, clothing and bedding.

From November until his death in February 2007, the man continued to tell discipline staff of the increasing pain that he was suffering. He was prescribed painkillers, which on at least two occasions had to be obtained from the healthcare centre at Parkhurst.

The man told staff and other prisoners that he was either suffering from, or had been diagnosed with, cancer. During his time at Camp Hill, he was not referred to a member of the mental health team. However, in February 2007, the man saw the prison doctor, as a large lump had developed on his stomach. It was during these assessments that the prison doctor referred him for a mental health assessment by one of his general practitioner colleagues.

On the day before his death the man made a call to his wife and spoke with a number of friends who were with her at the time. The man's conversation with his wife appears to have been light in mood, with him giving no indication as to the state of his mind or of any self-harming intentions he may have had.

The man was found hanging in his cell by an officer in the early hours on 23 February 2007.

THE INVESTIGATION PROCESS

1. An investigator from my office carried out the investigation into the man's death. Notices were issued to staff and prisoners informing them of the investigation and inviting them to contact my investigator should they wish.
2. My investigator visited Camp Hill and was shown the wing on which the man spent the last months of his life. He met with the Governor of Camp Hill, a member of the Independent Monitoring Board and the Police Liaison Officer. He also made himself known to a representative of the local branch of the Prison Officers' Association. My investigator reviewed the man's prison and health records in addition to other documentation made available to him, and interviewed a number of staff and prisoners.
3. An independent clinical review on behalf of the Isle of Wight Primary Care Trust was undertaken.
4. My investigator spoke with a Detective Sergeant from Hampshire Police, who is also acting on behalf of the Coroner. He confirmed that the police had no concerns with regard to the circumstances of the man's death. My investigator has also been in contact with the Coroner's office and a copy of this report will be sent to the Coroner to assist him with his enquiries.
5. One of my family liaison officers wrote to the man's wife on several occasions during the investigation. Although my family liaison officer did not speak directly with the man's wife my family liaison officer and investigator have both spoken to her legal representative offering to meet with them.

HMP CAMP HILL

6. Built in 1912 using prisoner labour from nearby Parkhurst, Camp Hill is a Category C training prison located on the Isle of Wight. Camp Hill has a varied regime with education and various offending behaviour programmes. Prisoners also have the opportunity to learn trades and gain work experience in both textiles and engineering. St Patrick's wing, where the man was located, is considered to be one of the quieter wings in the establishment and houses a large proportion of prisoners who find it difficult to cope with the prison environment.

7. Health services at Camp Hill and at the other two prisons on the Isle of Wight are commissioned by the Isle of Wight NHS Primary Care Trust. There are three nurses on duty from 7.30am to 8.00pm Tuesday to Friday, and from 7.30am to 5.30pm Saturday to Monday. During weekends and evenings, one nurse is on duty. General Practitioners (GPs) from Median Healthcare, a local community practice, attend Camp Hill for three, three-hour sessions each week. Evenings and weekends are covered by on call GP's from the local PCT. There is no nursing cover based at Camp Hill during the night.

KEY FINDINGS

8. The man who is the subject of this investigation had a history of self harm and attempts at taking his own life. In December 2002, he told staff at Camp Hill that he had lost his son to cancer and that his mother was also suffering from the disease. It is recorded that he once attempted to take his life, whilst on bail, but was saved by his brother.
9. In early 2003, the man's prison records show that he made at least three serious attempts on his life. It was during this period that he was sectioned under the Mental Health Act and spent a period of time at Ravenswood House. (Ravenswood House is a self-contained medium secure unit and is the base for the Wessex Forensic Psychiatry Service.)
10. On 25 July 2005, the man was remanded in custody at HMP Winchester. In October 2005, he was sentenced to five years' imprisonment.
11. On 15 September 2005, the man was found hanging in his cell. In response to his actions, staff opened an Assessment, Care in Custody and Teamwork (ACCT) booklet. (This document is used to assess, observe and support prisoners at risk of self harm. It highlights the problems and possible trigger points of a prisoner at risk of self harm, and delivers a multidisciplinary plan to give prisoners support and help through a period of crisis.) The man told staff that he was "stressed" out and was being intimidated by another prisoner. Staff recorded that he had placed the ligature around his neck so that he could be moved to the healthcare centre. On 25 September, the man deliberately made a number of cuts to his arms. On 15 November, it was recorded that he had no further thoughts of self harm and the ACCT booklet was closed.
12. On 7 November, the man was transferred from Winchester to Camp Hill. During his reception it was recorded on his prisoner record that his wife was his next of kin. (No telephone number or address was recorded, but no indication that the man may not have wanted to provide these details was indicated either.) That evening the man was admitted to hospital with acute abdominal pains. He returned to the prison the following day, transferring to the healthcare centre at Parkhurst on 12 November.
13. On 14 December 2005, staff at Parkhurst opened an ACCT booklet because of the man's agitated state. He had been concerned that he would not receive a visit from his wife before Christmas. However, after an assessment the decision was made to close the booklet. The man believed that his comments and actions had been taken the wrong way by staff.
14. The man was found with a ligature in his possession on 9 January 2006. Staff at Parkhurst immediately opened another ACCT booklet. It was also recorded that his mother was seriously ill at this time and that the man's mood was low. Over the following weeks he was seen on a regular basis by members of the Mental Health in Reach Team (MHIRT) at the prison.

The ACCT booklet was closed on 23 March 2006. (The case reviews are missing from the booklet so my investigator has been unable to establish in detail the reasons behind the closure.)

In response to my draft report Camp Hill has since provided my investigator with the case reviews as referred to above. The final review, on 23 March, records that the man had no thoughts of self harm or suicide, that he was expecting a visit from his family and that he felt that there was no need for the ACCT document to remain open. A post closure review on 30 March, records that he had had no problems since the closing of the ACCT document, the man stating that he felt stable and calm.

15. On 29 June, the man transferred back to Camp Hill from the healthcare centre at Parkhurst.
16. On 19 July, the man was found wandering around the prison when he should have been picking up his medication. In August, he told staff that he was being bullied for his medication, and in September staff raised concerns that he was possibly trading it. As a consequence, the man's medication was issued under supervision.
17. On 9 September, staff opened an ACCT booklet as the man had said that he had had enough of life and would be better off dead. He told staff that he was fed up with other prisoners pressurising him for his medication. The following day (10 September), the man was moved to St Patrick's wing. (St Patrick's wing is primarily occupied by older prisoners and prisoners who are considered to be more vulnerable.) At a case review on 21 September, the man asked for the ACCT booklet to be closed, telling staff that he no longer felt "hassled" by other prisoners.
18. On 27 September, the man's mother died. He was given phone calls by staff so that he could keep in contact with his wife and family.
19. On 13 October, staff removed sheeting from the man with which he was attempting to make a noose. Staff recorded that he was suffering from cancer and had difficulty coping, due to the loss of his mother who had died of the same illness. The man also told staff that he was seriously in debt on the wing and of his concern that other prisoners were bullying him for his medication. An officer opened an ACCT booklet on him. The man was assessed and a care plan implemented. On 16 October, the man was admitted to hospital, returning to prison on 18 October. During a review on 20 October it was decided to close the ACCT booklet. (ACCT assessments must be completed within 24 hours of an ACCT being opened, however on this occasion it took two days. I appreciate that during this time the man was in hospital. However, it is unfortunate that the first case review also took two days to complete rather than 24 hours. Although this had no bearing upon his death, I should like to remind the Governor of Camp Hill of the importance of completing such assessments promptly.)

20. During October 2006, Security Information Reports (SIRs) indicated that the man was being harassed for his medication and it was suggested his family would become 'involved' if he did not hand this over.
21. During that month, the man underwent surgery during which he was fitted with a catheter. On 28 October, he complained of being in pain. He told staff that he was having problems with his catheter and that he was passing blood. The following night, the man again complained of pain and staff obtained pain relief from the healthcare centre at Parkhurst. On the evening of 30 October, further pain relief was requested from Parkhurst. An officer recorded on the man's wing history sheets that healthcare staff in Parkhurst had told him that, "this is the last time that they would do this."
22. On 2 November, arrangements were made for the man to have additional bedding, if required, and to have additional access to showers. He was issued with painkillers to take during the night but he continued to experience pain. Towards the end of November, it was recorded that his testicles were swollen and that there was blood in his catheter bag.
23. At approximately 6.00pm on 29 November, the man once again complained of pain. Staff from St Patrick's contacted the healthcare centre at Parkhurst but were advised that nothing could be done until the morning.
24. On 1 December, an officer recorded that the man had threatened to remove his catheter. He had become hostile and threatening to staff, not accepting decisions that had been made and refusing to take his medication.
25. On 26 December, the man complained of ankle pain to an operational support grade officer (OSG). It was recorded in the man's wing history sheets that, as night time staff were unable to issue medication, he should go to healthcare the following morning. However, the following morning the man declined treatment.
26. On 23 January 2007, a nurse wrote in the man's medical record that wing staff had reported he was acting strangely, appearing vague and confused. The man was seen by the nurse who advised wing staff that he should be observed and that healthcare should be contacted if necessary.
27. The last entry in the man's wing history sheets was made by an officer on 17 February. He wrote that in the early evening the man rang his cell bell, telling staff that he was in pain. The man was given four Paracetamol tablets, and was told to see healthcare staff in the morning in order to obtain stronger medication.
28. A prisoner on St Patrick's wing, said that the man had told him and fellow prisoners that he was suffering from cancer. The prisoner told my investigators that the man had said he wanted to be with his mum in the weeks leading to his death. The prisoner said that the day before his

death the man had looked ill and had been in pain.

29. The doctor, a GP from Medina Healthcare, saw the man on 14 and 19 February about the pain from which he had been suffering and about a lump which had developed on his stomach. The doctor described the man as someone who appeared nervous and anxious at times but was always pleasant.
30. The doctor said that he was aware of the man's history of self harm, but meetings with him were always brief and had been focussed on his physical condition. The doctor said that he had never discussed cancer with the man. (However, my investigators have established, and it is noted on a number of prison records, that the man led both staff and other prisoners to believe that he was suffering from cancer.)
31. During his contact with the man on 14 February, the doctor had no concern about the man's mental health but referred him for further assessment to a colleague who held a mental health clinic at the prison. The doctor said that he had not known that the man had been sectioned under the Mental Health Act but knew the man had been prescribed Citalopram. The doctor said his concern:

“... was that he [the man] obviously hadn't had a mental health review for quite a considerable amount of time and had obviously been discharged from the mental health in reach team. So I wanted to make sure that actually somebody sits down and spends some time and explores whether he still has ongoing issues.”

(During interview the doctor said that patients prescribed antidepressants should be seen by a doctor for a review every six months or so.)

32. On 22 February, at 3.39pm, the man made a call to his wife and a number of friends/relatives who were with her at the time. The telephone conversation appears to have been light in mood and he gave no indication about his state of mind, or any self-harming intentions he may have had. At 4.17pm, the man spoke briefly to his wife again. He made a final call to a male friend at 4.18pm. He talked for less than two minutes before being cut off.
33. A therapeutic psychiatric nurse and member of the Mental Health in Reach Team (MHIRT) at Camp Hill, said that he did not have any formal contact with the man during his sentence. He said that he was not surprised that the man had had no contact as he had not expressed any thoughts of self harm. However, when told that the man had been on an ACCT document whilst at the prison, the psychiatric nurse expressed surprise that he had not been referred to a member of staff from the MHIRT.

In their response to my draft report Camp Hill reported that,

“There is no automatic referral to the Mental Health in Reach Team

(MHIRT) when a prisoner is subject to an ACCT process. Referral would only be made where the assessor considered there to be a specific Mental Health issue.”

34. A prisoner in a cell adjacent to the man said that at about 10.00pm on 22 February he heard someone speak with the man at his cell door and heard the man say he was in pain, but the person concerned told him that there was nothing that they could do. The prisoner was unable to confirm who spoke with the man. (My investigator has also been unable to establish who this was or if the man rang his cell bell at this time.)
35. At about 5.15am on 23 February, the OSG on duty on St Patrick’s wing, started to check prisoners for the early morning roll check. The OSG looked into the man’s cell. He told police that he could see the man, “... standing at the foot of his bed near to the sink and window at the far end of the cell.” The man’s position appeared strange, so the OSG called out and rapped on the cell door. The OSG turned the cell light on and saw that the man was suspended from a ligature attached to the window bars. He immediately called for assistance over the radio.
36. At 5.21am, an OSG based in the communications room, received a call from the OSG on the wing requesting that Oscar 1 attend St Patrick’s wing immediately. (During night shifts in prison, a night orderly officer, commonly known as Oscar 1 is responsible for the running of the prison.) Oscar 1, who was checking the perimeter fence, told the communications room that he would be a couple of minutes. This message was relayed back to the OSG on the wing. However, the OSG on the wing told the OSG in the communications room that it was urgent that Oscar 1 attend. This message was again relayed back to Oscar 1. Oscar 1 then asked what was going on. On speaking with the OSG on the wing for a third time, the OSG in the communications room established that a prisoner had been found hanging on the wing. Oscar 1 instructed the communications room OSG to tell officers in the segregation unit that they should attend St Patrick’s wing.
37. Two officers were told to attend St Patrick’s wing immediately. The first of these officers said that, after he had put his boots on, he and the second officer made their way straight to St Patrick’s wing, arriving several minutes later. The OSG on St Patrick’s was waiting by the office when the officers arrived and directed them to the man’s cell. On arriving at the cell the first officer unlocked the cell and entered immediately. On seeing the man hanging in a standing position in the corner of the cell between the bunk beds and outside wall, the first officer to attend attempted to break the ligature. The second officer returned to the wing office to fetch a pair of ligature scissors (scissors specifically designed to cut ligatures).
38. The ligature broke and the first officer loosened it from around the man’s neck. He checked for a pulse but could find none. The first officer believed the man was dead as he was stiff and cold to the touch. Oscar 1 arrived at the cell at approximately 5.25am and, on observing the situation,

confirmed with the first officer that he had checked for signs of life. Oscar 1 said that he believed the man had been dead for some time and that rigor mortis had set in. No cardio pulmonary resuscitation (CPR) was attempted. Both officers withdrew from the cell, preserving any evidence for the police.

39. Oscar 1 and the second officer then proceeded to the control room. The second officer returned to the cell office and remained on the wing with the OSG. In his police statement, the first officer said that several minutes later he returned to the man's cell in order to remove the ligature from around the man's neck. He did this in order to preserve the man's dignity.

40. At 5.30am, the duty governor was contacted. He advised that the death in custody contingency plan should be implemented immediately. At 5.34am, Oscar 1 contacted the healthcare centre at Parkhurst so the duty doctor could attend and pronounce the man's death (there being no nursing cover during the night at Camp Hill). Oscar 1 considered calling for an ambulance at this time. He said that, because paramedics would have been unable to do anything, it would have been pointless for them to attend. Oscar 1 said his priority was to get the doctor and police to the prison as quickly as possible.

41. The duty doctor was called by Oscar 1 at about 5.40am and was informed of the man's death. The duty doctor told my investigator:

"I asked him [Oscar 1] about the protocol for this situation which he obtained and it advised calling the ambulance, and I said that I would visit."

The duty doctor advised Oscar 1 that it was probably best if an ambulance was called.

42. At 5.58am, an ambulance was called. It arrived at 6.07am. The duty doctor said that:

"The ECG they [the paramedics] performed was flat and showed no evidence of electrical activity from his [the man's] heart."

The duty doctor certified the man's death at 6.28am.

43. Members of the prison's care and welfare team and Independent Monitoring Board were advised of the man's death. At 6.55am, staff discussed the circumstances of his death during a hot de-brief meeting. Statements were taken and staff were given access to members of the care team. Prisoners on open ACCT booklets were reviewed in light of the death.

44. At 7.08am, the duty governor asked the police to notify the man's next of kin of his death. It was recorded in the incident log that this action was taken as there were no contact details held by the prison. The man's wife

was informed of her husband's death at 11.42am by Sussex Police.

45. The man's family made contact with the prison that afternoon. The deputy family liaison officer assisted the family in arranging to view the man's body at the hospital mortuary. The man's wife and a number of relatives arrived at Camp Hill on 24 February. Although their arrival at the prison was unexpected, the deputy family liaison officer arranged for them to meet the prison chaplain, who was able to show the man's cell to his wife and members of her family.
46. On 2 March, a memorial service for the man was held on St Patrick's wing. It was attended by the Governor, staff and many prisoners who knew the man. Members of the chaplaincy and the family liaison officer represented the Prison Service at the man's funeral and the prison made a substantial contribution towards its cost.

Clinical Review

47. Isle of Wight Primary Care Trust has provided a clinical review into the care the man received whilst at Camp Hill. In his executive summary, the clinical reviewer said:

“The man was found dead in a single cell one morning in late February 2007. The cause of death given by the Home Office Pathologist was ‘ligature suspension’.

The Pathologist noted:

‘The death of the man was clearly the result of ligature suspension, the pathological features of which were wholly in keeping with wilful self-infliction.’

‘No evidence of any obviously painful or distressing somatic (physical) medical condition. However, the presence of numerous old incised wound scabs of the forearms and elbow folds typical of self-infliction at times of very low self-esteem, may be of relevance in determining the manner of death.’

In respect to ‘physical problems’, the man had a history of problems passing urine (this had been treated in October 2006 with an operation). He had also had recurrent discomfort in his groin/testicles and he had to contend with life-long anticoagulation medication. However, at post mortem, no serious physical pathology was found and in particular no evidence of cancer.

In respect to his mental health, the man had a long history of personality problems and resorting to self harm, including hanging.

Having considered the evidence, in my opinion, the healthcare that the

man received in HMP Camp Hill was equivalent to that he would have received in the Community.”

48. I am grateful to the clinical reviewer for his report. However, I believe there are a number of other issues of a clinical nature that would benefit from further review:

- Interventions made by mental health staff between January 2006 and February 2007.
- The clinical management of the man’s genito-urinary problems and pain relief.
- The appropriateness and effectiveness of prescribed medication in treating the man’s clinical and mental health conditions.

I therefore make the following recommendation:

The Chief Executive of the Isle of Wight Primary Care Trust should arrange a further review of the clinical care afforded to the man who died whilst in custody at HMP Camp Hill. This review should pay particular attention to the mental health interventions and their adequacy between January 2006 and February 2007. The review should establish whether the man’s genito-urinary problems were clinically managed effectively, the appropriateness of the medication the man received and whether his identified clinical conditions were treated effectively.

Post Mortem Report

49. The Post Mortem examination reported that the man’s death was as a consequence of ligature suspension.

ISSUES

50. There is no coded radio call system in place at Camp Hill for staff to use in an emergency, and during the night radios do not operate on an open network. (Emergency radio call signs are used by staff in many prisons when summoning assistance to suspected, or attempted, suicides and other medical emergencies involving prisoners. Examples include a code blue being called for prisoners who are experiencing breathing difficulties and a code red for those suffering from a loss of blood. An open network enables all staff in a prison to hear all communications made over the radio.) Although the OSG on St Patrick's wing reacted promptly when radioing for assistance in the early hours on the day of the man's death, it was not initially clear to the communications room operator, and as a consequence to the orderly officer, Oscar 1, what the nature of the emergency was. The OSG based in the communications room was required to make several calls before establishing that a prisoner had been found hanging.

51. I appreciate that there is no mandatory requirement for establishments to introduce such a code system and accept that minimal time was lost in raising the alarm. However, I know that many prisons have adopted code systems, finding them to be of great assistance in informing staff of the nature of an emergency. I therefore make the following recommendation:

The Governor should consider introducing a system of radio call signs for use during emergency situations. I recommend that consideration also be given to switching radios to an open network during such emergencies.

52. I note that one of the officers who responded had to put his boots on after being alerted to attend St Patrick's wing. Although I make no formal recommendation, I would remind the Governor that all staff should be in a state of readiness to respond promptly when required to do so.

53. On arrival at the man's cell, the first officer to attend entered immediately. Like all staff in the prison at the time he did not carry a ligature knife. Due to staff not being fully aware as to the nature of the emergency they were responding to, the second officer who attended had to return to the wing office to collect a pair of ligature scissors. It was fortunate that, while the second officer was absent, the first officer was able to loosen the ligature from around the man's neck and check for signs of life. Shortly after the man's death, ligature knives were issued to all staff working nights at Camp Hill as a consequence of the introduction of national policy. I need make no further recommendation.

54. Although staff at Camp Hill acted promptly in response to the emergency call, it is apparent that a certain amount of confusion followed. Some staff were unaware of the local procedures with regard to entering a cell at night in response to a suspected death. My investigator reviewed the local night instructions. He established that instruction 2.87, Nights – Death in

Custody/Suspected Death in Custody, lacked clarity in explaining to officers the procedures to be followed in the event of discovering a suspected suicide or death during the night. In particular, the instruction was lacking in guidance as to when to enter a cell and what action should be taken on discovering a prisoner in distress. For example, there is no instruction advising staff to take the weight and cut the ligature from a prisoner who is found to be hanging.

The Governor should review all Camp Hill's night instructions that relate to discovering a death or suspected death in custody. Particular attention should be focussed on when a cell may be unlocked and the staffing level that is required to do so.

55. It seems likely that the man who had been found by staff had been dead for some time when he was discovered. However, it took approximately 35 minutes before an ambulance was called. This delay appears to have been the result of some confusion as to what was the appropriate action to take in such circumstances. I note that the night instructions do not give any guidance as to when an ambulance should be called.

The Governor should draw to the attention of all staff the guidance relating to the discovery of a death in custody, and the actions to be taken including the calling of an ambulance.

56. A number of the post incident logs were not started until the arrival of the duty governor and a number had not been fully completed. I also note that a number of staff were not asked to attend the hot-debrief.

The Governor should remind all staff of the importance of completing accurate, timely and comprehensive logs.

The Governor should ensure that a hot de-brief involving all relevant staff takes place after any death in custody or other serious incident.

57. Shortly after 7.00am, the duty governor asked Hampshire Police to notify the man's wife of her husband's death. The incident log said that no contact details were held by the prison. Although the man's current address was not held by the prison on the Local Inmate Information System (LIDS), it was recorded on a number of visiting orders held in the man's prison record. I make no formal recommendation but would remind the Governor of the need to ensure that prisoners' next of kin details are kept up to date.

58. In section 3.1 of Camp Hill's procedural document 69, Handling a Death in Custody, it states that the next of kin should be notified as soon as possible. It adds that, when available, a family liaison officer will be appointed to contact the family. This guidance reflects in spirit the good practice laid out in the Prison Service's Guidance for Prison Family Liaison Officers contained in Prison Service Order PSO 2710. However, the guidance in paragraph 3.1 of Camp Hill's procedural document should

underline that notification of a prisoner's death to his family or next of kin should preferably be made in person by prison staff and not by the police. The PSO says that, when the distance is too great, staff should make an effort to contact a local prison in order to break the news, and that the police should only be contacted to inform the next of kin as a last resort.

The Governor should consider amending section 3 of Camp Hill's procedural document 69, Handling a Death in Custody, to reflect more accurately the guidance published in PSO 2710, Follow up to Deaths in Custody, when breaking the news of a prisoner's death to the next of kin.

RECOMMENDATIONS

The Chief Executive of the Isle of Wight Primary Care Trust should arrange a further review of the clinical care afforded to the man who died whilst in custody at HMP Camp Hill. This review should pay particular attention to the mental health interventions and their adequacy between January 2006 and February 2007. The review should establish whether the man's genito-urinary problems were clinically managed effectively, the appropriateness of the medication the man received and whether his identified clinical conditions were treated effectively.

Accepted – The Chief Executive of the Isle of Wight PCT will conduct a further review of the clinical care afforded to the man. It is intended that a suitable clinician from the Hampshire Partnership Mental Health Trust will conduct this review.

The Governor should consider introducing a system of radio call signs for use during emergency situations. I recommend that consideration also be given to switching radios to an open network during such emergencies.

Accepted – A review of the recommendation to use radio call signs will be completed. Advice will be given to controllers in respect of switching to the open network during such emergencies.

The Governor should review all Camp Hill's night instructions that relate to discovering a death or suspected death in custody. Particular attention should be focussed on when a cell may be unlocked and the staffing level that is required to do so.

Accepted – Both night instructions and contingency plans currently comply with this recommendation. Contingency plans were amended in March 2007 and Local instructions 2.77 and 2.87 refer.

The Governor should draw to the attention of all staff the guidance relating to the discovery of a death in custody, and the actions to be taken including the calling of an ambulance.

Accepted – Both local Procedural Documents and Contingency plans now reflect this recommendation. A local staff information notice will be issued to ensure staff are aware of these changes.

The Governor should remind all staff of the importance of completing accurate, timely and comprehensive logs.

Accepted – A Local Staff Information Notice will be issued to ensure staff are aware of this recommendation.

The Governor should ensure that a hot de-brief involving all relevant staff takes place after any death in custody or other serious incident.

Accepted – This requirement is currently included in the Contingency Plans. All Operational Managers will be reminded of this requirement in writing.

The Governor should consider amending section 3 of Camp Hill's procedural document 69, Handling a Death in Custody, to reflect more accurately the guidance published in PSO 2710, Follow up to Deaths in Custody, when breaking the news of a prisoner's death to the next of kin.

Accepted – An Amendment will be made to Procedural Document 65, Handling a Death in Custody.