The circumstances surrounding the death of a man
On 27 March 2005 at HMP Lowdham Grange

Prisons and Probation Ombudsman for England and Wales

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The man was aged 45 when he died, apparently at his own hand, on 27 March 2005 in his cell at HMP Lowdham Grange. This is a report into the circumstances surrounding his death. The loss of any family member is distressing, but especially so whilst they are in custody and I offer my sincere condolences to his family and friends.

The investigation was carried out by a member of my office. I would like to thank the Director of Lowdham Grange for making the necessary facilities available to my investigator. I am aware that since carrying out the investigation, the Director has left the prison and a new Director appointed. The new Director, following discussions with my investigator, has resolved some of the outstanding issues for the man's family, which had not been addressed previously. I am grateful for his personal pro-active approach to the findings of my report and dealing with matters with sensitivity. I am particularly grateful for the help and support of the prison's Liaison Officer.

In the course of the investigation, I asked for a clinical review of the care and treatment received by the man to be carried out. I am much indebted to Newark and Sherwood Primary Care Trust (PCT) for its generous offer to undertake the review, as this was outside its own contractual obligations with Lowdham Grange. The offer of assistance demonstrates the strong links that have been developed between Lowdham Grange and the local PCT.

My report makes a number of recommendations for the prison. Looking at what happened both before he died, and in the immediate aftermath of his death, there are several areas where improvements are required. However, I have been pleased to commend three examples of good practice as well.

That said, it is evident that he was experiencing serious difficulties in his relationship with his partner, something that was well known to staff and prisoners and which had previously resulted in his being monitored under the F2052SH (suicide and self-harm) procedure. It is regrettable that prison staff took the decision not to re-open the F2052SH, despite his distress following a succession of telephone calls little more than 24 hours before his death.

Stephen Shaw CBE
Prisons and Probation Ombudsman October 2005

Summary

1. At 11:45pm on Saturday 26 March, a Prison Custody Officer (PCO) began a routine check of the cells on F wing in HMP Lowdham Grange. The check required him to view the prisoners through the cell door observation flap and confirm that the prisoners were in their cells.

2. When he arrived at cell F5, he noticed that the man was sitting on the floor, with his back against the end of the bed, and his legs inside the toilet area. The officer spoke to him, but did not receive a response. He therefore summoned assistance from another PCO, who was also on duty on the wing. This PCO attempted to obtain a response from the man by banging on the door and calling out his name. As the two officers could not communicate with him, one PCO left the cell area and summoned assistance by telephone from the Night Duty Manager.

3. The Night Duty Manager attended the cell along with two further PCOs. He unlocked the cell door and saw that the man was suspended at the neck by a ligature. The ligature had been passed over the top of the toilet door and tied around a toilet brush, which was then anchored against the door and wall. The Night Duty Manager used an anti-ligature knife to cut and remove the ligature from around the neck and then laid the man on the floor in order to carry out cardio-pulmonary resuscitation (CPR). One of the PCOs began to give mouth to mouth resuscitation and continued until the nurse arrived.

4. A duty nurse received a radio call to attend F wing. When she arrived, she saw one of the PCOs performing mouth to mouth resuscitation. She checked for signs of life, but found that the man was not breathing and did not have a pulse. His pupils were fixed and dilated, his skin cold and cyanosed around the mouth. She began chest compressions and the PCO continued mouth to mouth resuscitation. They continued CPR until the paramedics arrived at 00:20am and took over the man's medical care.

5. The paramedics performed a heart trace. This gave no indication of a heartbeat, and they decided to stop any further attempt at resuscitation.

6. The man was taken to the Queens Medical Centre, Nottingham and pronounced dead at 05.54am by the Prison Medical Officer.

7. My report reveals both some good practice on the part of Lowdham Grange, as well as areas of practice where improvements are required.

The man

8. He was born on 1 January 1960 in Ireland and was aged 45 when he died at Lowdham Grange.

9. The man was 14 years of age when he received his first conviction and aged 44 when he received his current sentence. In total, he had 42 previous convictions recorded against him, seven of which were for violent offences, and had received 14 custodial sentences. On 24 July 2003, he was sentenced to six years imprisonment at Sheffield Crown Court for burglary offences.

10. He was from a travelling community, based in the Sheffield area. He and his previous partner had three children, but the relationship had broken down. He was in a new relationship and was engaged to be married and had two children with his new partner. His new partner said that she had encouraged him to see his children

HMP Lowdham Grange

11. The prison opened in February 1998 and is a privately managed establishment, operated by Premier Custodial Group Ltd, part of Serco Group plc. The prison stands on the site of the former Lowdham Grange Borstal.

12. The prison has a largely industrial based regime, but has seen an expansion of its education service over the period of time that it has been opened. It offers a variety of vocational training, domestic and kitchen work, gymnasium, gardening and offending behaviour programmes.

13. The prison offers single cell accommodation in two houseblocks, each comprising four wings. Nursing staff are directly employed by the prison.

Conduct of the Investigation

14. The investigation opened on1 April at Lowdham Grange. My investigator met with the Director and his management team and received a briefing about the circumstances surrounding the man's death. He then visited the cell where the man had been found.

15. A number of prison documents were made available by the Director, which the investigator read. The prison records and reports identified which members of staff the investigator would need to interview.

16. Several PCOs, managers and support staff were interviewed and in the majority of cases the interviews were carried out using recording equipment. Three prisoners, who had been transferred to various establishments, were also interviewed. These latter interviews were not recorded on tape.

17. A clinical review was commissioned to review the care and treatment received by the man during his time in custody.

Key findings

18. On 24 July 2003, the man was sentenced by Sheffield Crown Court to six years imprisonment. He was charged with seven offences, and found guilty of six of the charges against him.

19. Since February 2003, when he was on remand, five F2052SH documents had been opened. The F2052SH system is the Prison Service's procedure, also in use at Lowdham Grange, for monitoring those prisoners who are deemed at risk of suicide or self-harm. The monitoring system allows any member of staff who has concerns regarding an individual prisoner to open an F2052SH form. The unit manager and a member of the healthcare team assess the information and then make a decision regarding the level of observation that should take place. The prison has three levels of observation:

    - Level one: Irregular watch and observed at least every two minutes. The prisoner is located in the Segregation Unit and observed by a nurse or a PCO. Whenever this occurs every effort is made to transfer the prisoner to a prison with an in-patient healthcare facility as soon as possible.

    - Level two: 15-minute watch, at irregular intervals, with the prisoner kept on normal location, and observed by a PCO.

    - Level three: 30-minute watch, at irregular intervals, with the prisoner kept on normal location, and observed by a PCO.

20. Prison staff are required to make entries into the F2052SH record and note the time, date, and print their name, along with any significant observations that they may have. The prison carries out specific training to all staff regarding suicide and self-harm, which includes the completion of the F2052SH record. The High Risk Assessment Team (HRAT) reviews the F2052SH, and makes a decision regarding the level of observation required and/or whether to close the file. The HRAT meeting is chaired by the Suicide Prevention Coordinator. The team consists of an assessor, healthcare representative, unit manager, chaplain, the prisoner and any other interested party.

21. The man's most recent form was opened on 19 February 2005 (not 2002 as indicated on the front page of the form), and was closed on 14 March. Throughout the times that he was being monitored, the level of monitoring fluctuated between level one and level three. The documents show that the support offered to him was appropriate.

22. My investigator found that a number of entries in the F2052SH relating to the man did not show the name of the person making the entry and were not signed and dated. Additionally, a number of gaps were found between individual entries.

The Director should remind all staff of the need to accurately record their name, signature and date, when making an entry in an F2052SH and not to leave gaps between individual entries.

23. On 9 March 2005, the man was interviewed by the Criminal Justice Liaison Community Psychiatric Nurse (CPN), North Nottinghamshire Community Forensic Service and another CPN. The health assessment was requested following a referral made by the prison's Psychology Department, due to the man's *persistent low mood, exacerbated by problematic social issue outside prison, and recent laceration of his wrists.* On 10 March, the Criminal Justice Liaison CPN wrote a report to the Prison Medical Officer, Lowdham Grange Healthcare Centre, regarding the interview. She noted that *there remains the risk of impulsive acts of self-harm/suicide as the relationship difficulties continue, which seems likely at this time.* Unfortunately, due to annual leave, the letter was not read by the Prison Medical Officer, until after the man's death. I understand that the letter was also sent to the Clinical Manager, Senior Psychologist and Consultant Psychiatrist, and they concluded that, as the letter did not contain any action points and was for information only, that they were aware of, they took no further action with the contents. My investigator asked if the prison had any formal arrangements in place to allow external agencies to pass important information into the establishment and was informed that they did not.

    The Director should seek to develop protocols with external agencies, which would allow essential information to be passed to the prison.

24. The relationship problems that the man had with his partner were well known to wing staff, as he would openly display how upset he was and discuss his feelings with them. On 25 February, he cut his wrists, which was thought to be a direct result of his relationship problems. As a result, he was placed on F2052SH level one monitoring.

25. On 25 March, he expected to receive a visit from his partner but she did not arrive. He made six telephone calls to her during the afternoon. Staff on the wing described them as angry exchanges, and they could see that he was visibly upset at the end of the calls. The transcripts of the calls confirm that he made six phone calls to his partner, throughout which he pleads with her not to end the relationship, and she insists it is over. During the calls, he indicated to her that he was going to end his life. By the end of the sixth call, it was evident that the relationship difficulties had not been reconciled.

26. Another PCO had previously assisted the man with reading and writing and had come to know him well. He was fully aware of his domestic problems and of the telephone calls that day. Due to the level of his concern for the man, he spoke to the Unit Manager who responded quickly and made arrangements for the man to be seen the same day by a member of the healthcare team and a prison counsellor.

27. The Unit Manager also knew the man well and had previously been a member of his HRAT meetings. He was aware of the reasons why the man had been placed on F2052SH monitoring, as well as knowing about his self-harm history.

28. The investigator asked the Unit Manager if either he or the PCO had opened an F2052SH following the telephone calls. He confirmed that they had not, but had considered it and thought that it was not necessary on this occasion. The man was known to threaten to harm himself and did so when his relationship with his partner was in difficulties. On earlier occasions the suicide and self-harm monitoring arrangements were put in place, and it is difficult to understand why it was not done on this occasion.

29. The prison counseller holds the European Diploma in Therapeutic Counselling 2000. She had seen the man on a number of occasions to discuss his suicidal and self-harm thoughts and had been a member of the HRAT meetings involving him. She was aware of the difficulties he was experiencing with his relationship. She knew that whenever problems arose in his relationship, he was at high risk of self-harm. In February 2005, following a difficult period in the relationship, he had informed the counseller that he intended to harm himself, which he later carried out by cutting his wrists.

30. Following the telephone call from the Unit Manager on 25 March, the prison counseller interviewed the man and he informed her that his partner had told him on the telephone to *cut up and hang himself.* The counseller said that when she saw him that day, he appeared upbeat and she did not consider him to be at risk of self-harm.

31. Each wing has a Staff Observation Book. The book is available to any member of staff to record and pass on information and observations to the wing staff. My investigator examined the observation book entries and identified an entry dated 23 March which said *keep an eye on the man, down again.* The entry is signed but unidentifiable.

32. The investigator enquired why the information about the man's distressing telephone calls was not recorded, and why the interventions of healthcare and the counsellor were also not recorded. The Unit Manager was unable to explain why he had not made any entry. The PCO said that it was his intention to make an entry in the observation book after the weekend and said, *to have written it earlier would mean that he was writing to himself*. The prison counseller said that she had not considered making an entry in the book.

33. It was clear to my investigator that the wing observation books were not being used correctly and to their full potential. He raised this with the Director, who made immediate arrangements to remind all staff of the need to use the observation books.

34. Premier Prisons' own Investigation Officer informed my investigator that the man's partner had said she had telephoned the prison to inform them that he was feeling suicidal. She could not recall the date, time or name of the person that she had spoken to. She also informed my Family Liaison Officer (FLO) of her attempt to warn the prison of his suicidal thoughts, saying that she had telephoned, written and had spoken to prison staff when she last visited the prison. It has not been possible to substantiate her information, as there is no written record of the warnings being received at the prison. The investigator enquired whether there was a procedure to allow staff to record information from friends or relatives who may be concerned about a prisoner, but there are no such arrangements.

    The Director should introduce a system for staff to record information from members of the public and pass on the information, as appropriate.

35. PCOs are required, as part of their normal duties, to work during the night. They are responsible for making periodic checks throughout the night and to confirm that the prisoners are secure. They also respond to any cell call alarms, and carry out general administration duties. When officers initially arrive on the wings to commence night duty, they accompany the evening duty officers who lock prisoners into their cells for the night. The evening duty officers carry out a full roll count by opening the cell doors to confirm that the cell is occupied and that the prisoner is alive. When evening staff have carried out their roll count, the night patrol officer physically checks that the door is locked and secure. Evening duty staff confirm the wing roll to the Duty Manager and, once the roll is accounted for, they are allowed to leave the prison.

36. Each night patrol officer is issued with a radio and a cell key. The key is carried at all times and kept in a leather pouch, which is sealed with a plastic, numbered, security tag. The officer can break the security seal in an emergency situation and, providing the officer believes it is safe to do so, enter the cell. Additionally the officer can request assistance by using the UHF radio *urgent message procedure*, or by dialling 222, which is the emergency telephone number and goes directly to the prison control room.

37. Night patrol officers are required to patrol the wing and are given specific predetermined instructions regarding the route that they must take. At strategic points around the wing there are a number of magnetic strips, which the officer has to visit. Each officer is issued with a hand held recording device, known as a Morse gun, which is placed against the magnetic strip. The gun memory records the action and location of the magnetic strip and, at the end of the officer's duty, the memory is downloaded into a computer, which allows the manager to check that the specified patrol has been carried out.

38. At approximately 10:00pm, the night patrol officers are required to carry out a full roll check of the prison and to report their roll to the Night Manager. The roll check confirms that the prisoner is in his cell. The Night Manager collates the prison roll and records the figures.

39. During the night, PCOs at Lowdham Grange are also required to carry out at least three flap checks. Flap checks mean that the officer is required to lift the cell door observation cover to check that the prisoner is present and alive. This procedure is good practice, as it provides additional observation of the prisoner during the night-time period. In the man's case the procedure meant that he was discovered earlier than would otherwise have been the case.

    The additional night time observation checks are good practice.

40. Each wing is monitored 24 hours per day by video camera, and the image recorded onto videotape. The video equipment records the images at three second intervals, and not as a continuous picture. The resulting picture, when played back, produces an image that appears faster than normal motion.

41. At 9:15pm on 26 March, a PCO commenced duty as a night patrol officer. His duty that night was to patrol Houseblock Two, E and F wing. He received a handover from the evening duty staff, but no information specifically about the man. However, he did recall that he had been informed that the man had had a *bad call from his wife,* but could not recall what day this was. He confirmed that there were no entries in the wing observation book to indicate that the man had upsetting telephone calls, had been assisted by staff and the counsellor or that he was considered as being in a vulnerable frame of mind.

42. At approximately 10:05pm the PCO carried out a full roll check of F wing and confirmed to the Duty Manager that the roll was correct. He recalled seeing the man alive, and that he was sitting at his table listening to his radio.

43. The investigator asked to view the video recording for F wing in order to confirm that the PCO had carried out his flap check and roll check. Unfortunately, whilst the camera monitor located in the wing office was showing an image, the video recorder was faulty and the images were not recorded. The prison management was unaware of the failure of the system until my investigator informed them of it.

    The Director should ensure that all video monitoring equipment is regularly checked and maintained in full working order.

44. Although the video recorder was not working correctly, the Morse Gun log shows that the gun memory was activated by the magnetic monitoring strips at the correct times.

45. At approximately 11:40pm, the officer commenced the flap check, beginning at cell number one, and moving along in a clockwise direction. About five minutes later, he looked into cell number five and saw that the man was sitting on the floor, with his back against the foot of the bed and

his legs inside the toilet area. He attempted to obtain a response from him, but was unable to do so. The Officer asked another PCO, who was in the wing office, to assist him.

46. At approximately 11:46pm, both PCOs returned to the cell. One PCO banged on the cell door to attract the man's attention, but was also unable to obtain a response. One PCO returned to the wing office and telephoned the Night Duty Manager, who was on Houseblock One, and requested his assistance.

47. The investigator asked the PCOs why they did not enter the cell, as they both had a cell key. The officers said that they did not feel that it was safe to enter the cell, but were aware that they could have done so. Considering that two trained officers were present at the cell and clearly unable to obtain a response from the man, it is difficult to understand why they felt that they were unable to enter the cell. Additionally, the officers were asked why they had not used the radio to alert the control room to locate the night manager. The officers said that they did not wish to alert other prisoners to what was happening and, as they knew where the Night Duty Manager was, they decided to telephone him instead. The officers were asked if they were aware of the urgent message procedure, and both confirmed that they were. However, when asked by the investigator to describe how they would transmit an urgent message, they did not give the correct response.

48. Whilst the delays may not have had a detrimental effect on this occasion, it could be the case that valuable time was lost by failing to use the radio equipment provided and by not entering a cell promptly.

    The Director should ensure that all staff required to carry a prison radio are competent to transmit and respond to an urgent message.

49. The Night Duty Manager commenced duty at 6:45pm and received a handover from the day Duty Manager. At 10:30pm, he carried out a routine check of the prison. At 11:20pm, he was called to Houseblock One to re-set the electric supply, as the power had failed in the wing. At 11:40pm, he received a telephone call from a PCO informing him that he was unable to obtain a response from the man and asking him to attend Houseblock Two. He responded immediately to the call, accompanied by two PCOs who were on duty in Houseblock One.

50. When he arrived at the cell, he unlocked the door and saw a ligature secured at the top of the toilet door by a toilet brush and around the man's neck. He was carrying an anti-ligature knife, which is specifically designed to allow the user to get underneath the ligature and cut it. He explained that he had difficulty placing the knifepoint under the ligature, as it was extremely tight. He cut the ligature at a point away from the neck, which then released the pressure on the noose and allowed him to lift the noose from the neck. Once released from the ligature, he laid the man on the floor in preparation for medical assistance to be given.

51. A PCO checked for signs of life but was unable to obtain a pulse or any sign of breathing. She immediately began mouth to mouth resuscitation and CPR, together with a nurse, who had responded to a radio call from the prison control room.

52. The nurse is normally based at HMP Doncaster and was working at Lowdham Grange because the prison had insufficient nursing staff. It was her first visit to the prison. At approximately 11:40pm, she received a radio message asking her to attend Houseblock Two. A grab bag was available, but she did not take it, as she had not been informed of the type of incident, or that the request was for urgent medical assistance. Additionally a defibrillator was available, but as she was unaware of the nature of the medical request, it was not taken.

    The Director should ensure that calls for medical assistance indicate the nature of the assistance required, so that medical staff are in possession of the appropriate equipment when requested to attend a patient. Additionally, all medical staff should be reminded that they are to take the "Grab Bag" to every request for medical assistance and consideration given to including a defibrillator in the grab bag.

53. At approximately 11:50pm, the nurse arrived at the cell and saw the PCO carrying out mouth to mouth resuscitation. In interview, she could not recall if CPR had commenced. She checked for signs of life and, with the PCO, continued with CPR until the arrival of the paramedics.

54. About 22 minutes later, the paramedic team arrived and began to check for signs of life. The heart monitoring equipment was attached to the man and gave a flat line reading. This indicated that he was dead, and so they decided to stop any further attempts at resuscitation. The paramedics left the cell area and went to the wing office to complete their report. The nurse and the PCO decided to remain with the man, as they did not want him to be alone. This was a simple act of decency and demonstrated a high level of care.

    The Director should commend both the nurse and PCO for their efforts to resuscitate the man and for the level of care and decency shown to him following his death.

55. Although the wing camera had not recorded the events at the cell, a video recording was available from the wing entrance camera, which gave accurate timings of staff entering and leaving the wing.

56. Following any death in custody, the area is sealed off pending the attendance of the police. This is normal practice and is done to preserve any evidence, as the area is a potential scene of crime. Once the paramedic team left the wing, the Night Duty Manager locked the cell door pending the arrival of the police. The video evidence shows that the police arrived on the wing at 00:44am.

57. At approximately 01:50am, the nurse returned to the Healthcare Centre to make an entry in the Inmate Medical Record (IMR). As she was making her entry in the IMR, she noticed that the record said that the man was on an F2052SH, level three, 30-minute observation. The record was incorrect, as the F2052SH was closed nearly two weeks earlier and this was not transferred to the IMR.

58. Police Officers removed a number of items from the cell for examination, including three cassette tapes, one of which contained a message from the man to his family. My investigator understands from the police officer dealing with the case that a copy of the tape has been passed to the man's partner. The cell was released back to the Director, as no criminal investigation was taking place. The Director made arrangements for the cell to be blessed and, following the man's funeral, the cell was re-decorated.

59. Prison emergency procedures allow for both main gates to be opened at the same time, the procedure is known as "Gate Override". Gate override reduces the delay in allowing emergency vehicles into the prison. The procedure requires the person operating the gate systems to be specifically trained to carry out the task. My investigator examined the emergency systems for 26 March. He found that the gate override system had not been operated and that the PCO in charge of the gate during the night was not trained to perform the override procedure. The short delay in allowing access by the emergency services did not make any difference in this case. However, the potential delay could have been vital in a different situation.

    The Director should ensure that all staff required to operate the gate systems are competent to operate the override procedures in the event of an emergency.

60. Following any serious incident in prison, the Director undertakes a series of de-brief meetings to establish the events and circumstances. The first de-brief is known as a hot de-brief and usually takes place before those involved leave duty. This is to ensure that recollections of events are recorded as accurately as possible. The second meeting is known as a cold de-brief and allows all those involved to examine the incident collectively, and to look at what was handled well and what areas could have been improved upon.

61. The prison has a system in place that allows any member of staff to receive individual counselling and advice from an independent organisation. The facility is well publicised and confidential, so that the Director cannot monitor staff access or attendance.

    The confidential counselling arrangements are good practice.

62. My investigator discussed the incident de-briefs with a number of staff and found that on the majority of staff felt supported. However, there was a small number of staff who had not attended the cold de-brief, as they were unaware of the meeting and consequently felt unsupported.

    The Director should ensure that all staff involved in an incident are informed of de-brief meetings.

63. Prior to beginning the investigation, notices were displayed which informed staff and prisoners of the contact details for the investigator. There were no replies from prison staff, but three replies from prisoners who had known the man. They all described him as having relationship difficulties, and said that they would offer him support. One prisoner facilitated a three-way telephone between the man and his partner, as the man had no credit left on his telephone account. Another prisoner described the support received by the man from the prison staff as very good, whilst another one said that he felt the care plan support was poor.

64. I try to involve the family of the person who has died in prison in the investigation process, and take into consideration any concerns they may have about the care and treatment of their relative. One of my FLOs contacted the man's partner and sister, to explain the investigation procedure and enquire whether they had any concerns.

65. His partner's main concern was that she said she informed the prison of his suicidal thoughts but considered that nothing was done. I have considered this issue earlier in the report.

66. His sister also raised issues about his property, which was passed to his partner. They had also noticed bruises and cuts to his face and hands. Finally, they said that assistance with the funeral expenses had not been offered.

67. My investigator has established that prison records show that the man had said that his next of kin was his partner, which was the reason the property was returned to her. In relation to the marks on his body, the Post Mortem Report notes a number of marks which are reported as being consistent with attempts at resuscitation. Finally, the FLO contacted the prison's Director regarding a contribution towards the cost of the funeral and this was subsequently paid.

    The Director should review the prison's contingency plans to ensure that an offer of payment towards funeral costs is made promptly.

68. The man's partner said that she had asked the Director for permission to visit the cell where he died and speak to the prisoner in the adjacent cell. She said that she was told to put her request in writing to the Director, which she said she did. My investigator discussed the request with the Director, who said that he did not offer the opportunity for the man's partner to visit the cell, as she had previously been aggressive towards

him. The Director also said he was aware of her request to view the cell via my FLO, but again it had not been put in writing. The Director explained that, following the man's death, the cell was re-decorated and a new prisoner had been allocated to the cell. He considered that allowing the man's partner to visit the cell would be inappropriate and that he would not be allowing a visit to take place. However, I am pleased to be in a position to add that the new Director has since reviewed the decisions taken by his predecessor and agreed to allow the man's family to visit the cell where he died. He asked the man's partner to telephone him to arrange the visit, this was communicated to her and a date agreed for the visit to take place.

The Director should ensure that the advice given in PSO 2710 "Follow up to Death in Custody" is followed.

69. The clinical reviewer concluded in his report that the quality of Primary Care delivered by the Healthcare team at the prison was of a high quality and that it was consistent with the Clinical Guidelines on the management of depression.

Recommendations

1. The Director should remind all staff of the need to accurately record their name, signature and date, when making an entry in an F2052SH and not to leave gaps between individual entries.

2. The Director should seek to develop protocols with external agencies which would allow essential information to be passed on.

3. The Director should introduce a system for staff to record information from members of the public and pass on the information, as appropriate.

4. The Director should ensure that all video monitoring equipment is regularly checked and maintained in full working order.

5. The Director should ensure that all staff required to carry a prison radio are competent to transmit and respond to an urgent message.

6. The Director should ensure that calls for medical assistance indicate the nature of the assistance required, so that medical staff are in possession of the appropriate equipment when requested to attend a patient. Additionally, all medical staff should be reminded that they are to take the "Grab Bag" to every request for medical assistance and consideration given to including a defibrillator in the grab bag.

7. The Director should ensure that calls for medical assistance indicate the nature of the assistance required, so that medical staff are in possession of the appropriate grab bag when they are requested to attend an incident.

8. The Director should ensure that all staff required to operate the gate systems are competent to operate the override procedures in the event of an emergency.

9. The Director should ensure that all staff involved in an incident are informed of de-brief meetings.

10. The Director should review the prison's contingency plans to ensure that an offer of payment towards funeral costs is made promptly.

11. The Director should ensure that the advice given in PSO 2710 "Follow-up to Death in Custody" is followed.

Good Practice

1. The additional night time observation checks are good practice.

2. The Director should commend both the nurse and PCO for their efforts to resuscitate the man and for the level of care and decency shown to him following his death.

3. The confidential counselling arrangements are good practice.