

**Investigation into the death of a man
whilst in the custody of HMP Brixton in March 2008**

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

October 2009

This is a report of an investigation into the death of a 39 year old man. This was not his first time in prison. He was found hanging in his cell at HMP Brixton having been at the prison for less than 24 hours.

I would like to offer my sincere condolences to his family for their loss. I hope that my report addresses the concerns that they have raised.

The investigation was carried out on behalf of the Ombudsman by my investigator. I must apologise for the length of time taken to produce the report. This is clearly unacceptable and no doubt caused additional anxiety to his family at an already difficult and sad time. A final clinical review which was commissioned to consider his healthcare whilst he was at Brixton was not received until 2 June 2009. However, I would like to thank the clinical reviewer for his thorough and full review. I would also like to thank the Governor of Brixton and his staff for their assistance with my investigation.

The man had a history of harming himself, depression and alcohol and drug dependency. In addition to these concerns, the sexual offence with which he was charged should have been a trigger for him to be considered at risk of harm. Of course I cannot say that he would have lived if a suicide and self harm monitoring had been opened, but staff would have been alerted to the possible risk. A note he left in his cell said that he was not guilty of the charges and wanted his name to be cleared.

On a more positive note, I am impressed by the induction arrangements for new prisoners at Brixton and the care and professionalism shown by staff who tried to resuscitate him. However, it is unfortunate that the family liaison arrangements at the prison were less effective, and his family found them unhelpful.

I make eight recommendations to the Governor, five of which are also directed to the Head of Healthcare. This is not the first time I have made recommendations to Brixton regarding reception, healthcare assessments in reception and the role of the Family Liaison Officer at the prison.

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

Jane Webb
Deputy Prisons and Probation Ombudsman

October 2009

CONTENTS

Summary

The Investigation Process

HMP Brixton

Key Findings

Issues

Conclusion

Recommendations

SUMMARY

The man was found hanging in his cell at HMP Brixton. He had been at the prison for less than 24 hours. He had previously spent time at Pentonville prison, but had been released on licence in 2007.

He had a history of harming himself, depression and alcohol and drug use. He had scars on both forearms where he had previously cut himself. He spent 11 days in a psychiatric hospital in 2007. Just over a month before he arrived at Brixton, he took a drug overdose and was admitted to Queen's Hospital, Romford. He told prison staff that he was currently receiving medication for his depression and blood pressure.

The reception officer who first interviewed him said he did not realise he was charged with a sexual offence, despite it being highlighted on the Prisoner Escort Record (PER) form completed by the police. The man himself said he was in prison for breach of bail. The reception officer did not consider opening an Assessment, Care in Custody and Teamwork (ACCT) for him (a tool used to monitor prisoners at risk of harming themselves or of suicide).

The man next saw the acting head of healthcare. She too said that she did not realise the nature of his charges, even though she herself had written it on the front of the First Reception Health Screening form. The acting head of healthcare did discuss the man's history of depression, his previous attempts to take his life and his alcohol and drug dependency. However, he told her he had no intention of harming himself now and she made a judgement that it was not necessary to open an ACCT. She completed the secondary health screening for him at the same time.

The man was then seen by the prison doctor who prescribed medication for alcohol withdrawal. The doctor asked healthcare to check the medication and the dosage that the man said he was prescribed by his community doctor. He would not prescribe him any other medication until this information was obtained.

After the man completed the reception process, he was taken to a cell on C wing and settled in for the night. It was a shared cell, but the man's cell mate was transferred off the wing early the next morning. Sometime in the morning the man was given another dose of alcohol withdrawal medication.

Later that morning the man attended an induction course for new prisoners. The officer who ran the course recalled that he participated fully, asked questions and showed an interest in the library visit that afternoon. In the meantime, healthcare continued to make the necessary checks with his community doctor to confirm the medication he had been prescribed for depression and blood pressure.

The man returned to his cell at lunchtime. Around 2.00pm, the first officer on the scene unlocked him to collect him for the afternoon induction session. She got no response when she called out and could not see him, so she asked an officer on the wing where he was. When she was told he was in his cell, she returned and looked through the observation panel which shows the cell toilet area. The officer thought that the man was looking out of the window. She went inside and asked why he had

not responded a few minutes earlier. As she again got no response she went into the toilet area and saw him hanging from a bed sheet which appeared to be tied to window bars.

Staff responded quickly to the emergency call and carried out Cardio Pulmonary Resuscitation (CPR) until the paramedics arrived. Despite their efforts, the man was pronounced dead at 3.07pm.

THE INVESTIGATION PROCESS

1. The investigation was conducted on behalf of the Ombudsman by my investigator. On her initial visit to HMP Brixton she met staff and visited the cell where the man had died. Notices were issued to staff and prisoners informing them of the investigation and inviting anyone with information about his death to contact her, but no witnesses came forward.
2. My investigator reviewed the man's prison and health records in addition to the police's Prisoner Escort Record (PER) form. Interviews were conducted with 14 members of staff over several different dates, 13 June, 24 July, 4 September and 6 October 2008.
3. The Ombudsman commissioned a clinical review from Nina Murphy Associates LLP on behalf of Lambeth Primary Care Trust (PCT). The clinical reviewer accompanied my investigator to Brixton on 6 October to interview a member of healthcare staff who saw the man on his reception into the prison.
4. My family liaison officer contacted the man's family to explain the purpose of the investigation and invite them to raise any concerns they wished to be considered. A meeting was arranged with his family's solicitor on 23 July 2008. My investigator, my family liaison officer, the man's daughter and her mother attended. A number of issues were raised which included:
 - Whether the man had been on any medication?
 - Why the man was not on "suicide watch"?
 - Whether he was asked about any mental health problems or health concerns on reception?
 - Whether any member of staff had seen scars on the man's forearms and identified a possible risk and in particular whether staff were aware that the man had previously been on an ACCT?
 - Whether any previous prison records would have arrived at Brixton while the man was there?
 - Whether he had been in a single cell?
 - What the man had used as a ligature and how he had done this and how long it had been before staff discovered him?
 - Whether police records would be accessed to see if there had been any concerns about the man whilst he was in police custody and what concerns were passed on to the prison?
 - If the fact that the man had been questioned about child abuse allegations was a factor in his death?
 - Concerns about the effectiveness of the prison's Family Liaison Officer.

I hope that this report helps the man's family better understand what happened to him in the time leading up to his death.

HMP BRIXTON

5. HMP Brixton is a local Victorian prison dating back to 1819, serving a number of courts in South London. It holds both sentenced and remand prisoners with a high daily turnover. The prison can hold up to 798 prisoners within four main residential units and a healthcare inpatient facility.
6. Since the Ombudsman began investigating deaths in custody in 2004, there have been 14 deaths at the prison, both from natural causes and self inflicted. In 2005 I made recommendations regarding reception procedures and healthcare assessments in reception. In 2006 I made a recommendation regarding the Family Liaison Officer and returning the deceased property to the family, although these do not necessarily impact on this case.

Her Majesty's Chief Inspector of Prisons (HMCIP)

7. Brixton was most recently inspected by HMCIP during a full unannounced inspection in April and May 2008. The Chief Inspector said in relation to new prisoners arriving at the prison:

“ ... The environment in reception is poor, although staff treated new arrivals properly. First night procedures were satisfactory, but not all prisoners received an induction.”
8. With regard to reception, first night procedures and induction, the report says:

“ ... The reception area had recently been redecorated and cleaned, but it remained cramped and oppressive, with some very poor holding rooms. Staff were, however, respectful towards prisoners and aimed to move them through reception as quickly as possible.

“ ... Since our last inspection, the first night centre had been moved to better accommodation on C wing. A recently introduced Insider peer supporter scheme was benefiting new arrivals. The arrangements to identify the cell locations of new arrivals required improvements, and some new arrivals had not received entitlements such as a shower or reception.

“ ... A two-day induction programme began the morning after a prisoner's arrival, with contributions from officers, Insiders and representatives from key departments. The content was generally good and useful, but attendance was variable and record keeping poor. Not all prisoners who needed to attend a full induction actually did so.”
9. Finally, with regard to a member of healthcare assessing a new prisoner:

“ ... New arrivals were seen by a member of the healthcare team for a first night health assessment. Referrals were made to other services, such as the mental health in-reach team, as required.”

10. In respect of self-harm and suicide at Brixton, the report says:

“... There had been seven self-inflicted deaths in the previous two years. Initial assessments for prisoners at risk were good, but care maps and ongoing care were sometimes rushed and carried out in isolation. The suicide and self-harm strategy was up to date. Meetings were well focused, multi-disciplinary and strategic. The environment made it difficult to manage and distract vulnerable and at-risk prisoners.”

11. The Chief Inspector also commented:

“... Suicide and self harm structures were satisfactory, but the quality of self-harm monitoring documents varied.”

Independent Monitoring Board (IMB)

12. An IMB is appointed to each prison by the Secretary of State for Justice. Its members are independent of the Prison Service and the prison's management team. Each IMB is required to produce an annual report to the Secretary of State about the prison, highlighting good practice and areas of concern.

13. The most recent report for the period 1 July 2007 to 30 June 2008 makes the following observations regarding the first night centre and induction procedures:

“... Since July 2007 induction has been held in its new room on C wing. C Wing also holds first nighters and Rule 45 prisoners. Interviews are held as soon as prisoners arrive in the prison and thereafter they are transferred to C wing which is also the holding wing, until prisoners are transferred out. Staffing levels, compared with some other wings, are reasonably good. The packs for new prisoners are generally more complete than this time last year, although pillows are still regularly missing from them.

“... Induction takes place Monday to Friday and includes presentations from the IMB, Chaplaincy and the Education Department. Prisoners receive information about sending and receiving mail, parcels, reception visits, canteen and telephone calls, the use of the library, substance misuse and other relevant information...”

14. With regard to reception procedures and the nursing assessment of a new prisoner, the IMB says:

“... The demands on the time of staff in reception continued to be problematic. They work intensely in the morning and late in the evening when the vans depart and return.

Further the nurses who meet each prisoner to carry out a medical check, take a history and perform risk assessments, seem to do a tremendous amount of work in very little time available to them. The best nurses are used for this important job and the Board commends this practice.”

Assessment, Care in Custody and Teamwork (ACCT)

15. ACCT requires any member of staff who identifies concerns about a prisoner at risk of harming themselves or of suicide to take action and record those actions. Within 24 hours of the ACCT document being opened, the prisoner is seen by an assessor and has a case review meeting. ACCT reviews are held at appropriate intervals and are attended by the prisoner and a case manager, together with other members of staff including a representative from healthcare.

Anti-ligature knives

16. Anti-ligature knives, also known as ‘fish-knives’ are designed to cut ligatures. All staff who have contact with prisoners must be provided with, and carry on duty, their own personal knife.

Canteen

17. This is the prison shop where prisoners can buy or order goods each week to a limited value. It mostly sells food, confectionery, stationery, toiletries and tobacco products.

Listeners and Insiders

18. The prison has a Listener scheme which is a system where the Samaritans train selected prisoners to be the first contact for any prisoner who is feeling vulnerable or at risk. The scheme is confidential and any prisoner can ask to speak to a Listener at any time. The prison also runs an Insider scheme. Insiders are experienced prisoners who help new prisoners settle into prison life and answer any questions.

Rule 45

19. Prison Rule 45 relates to the separation of prisoners for either the good order of the prison or for the protection of vulnerable prisoners.

Telephone calls

20. Prisoners have access to telephones on the wing. Each prisoner is given a unique PIN number to access their account and are only able to dial authorised numbers.

KEY FINDINGS

21. On 15 March 2008, the man was arrested for an alleged sexual offence and taken to Limehouse Police Station. At 6.15pm it was reported by a police medical officer that he had “the illnesses of high blood pressure, phobia and depression. A history of previous attempts on own life”.
22. However, an assessment was carried out by a police sergeant who said that the man was not suffering from any physical or mental condition at the time.
23. Just over 15 minutes later, a medical review was undertaken by a doctor, which mentioned that the man had a history of chronic alcohol dependence, hypertension and depression. He was receiving sertraline 200mg daily (a drug prescribed for depressive illness and obsessive-compulsive disorder), carbamazapine 200mg in the morning (prescribed for varieties of epilepsy and prophylaxis of bipolar disorder) and atenolol 50mg daily (prescribed for raised blood pressure). The doctor noted that the man had consumed alcohol that morning and had taken an overdose ten weeks previously. The medical advice for the man was “close supervision”.
24. The following day (a Sunday) a note was made on the Prisoner Escort Record (PER) form that the man had both a medical and mental health condition. He had been arrested for a sexual offence (this was circled on the PER) and there were concerns about self harm and suicide. The police did not tick the appropriate box on the PER to record that he had drug/alcohol issues. However, the police recorded further information about his risks, which were as follows:
 - “High blood pressure and phobia
 - Suffers from depression
 - Arrested for a sexual offence
 - Previous attempts on own life
 - Violence markers on PNC (Police National Computer).”
25. The next day, the man was taken from Limehouse Police Station to Thames Magistrates’ Court. Part B of the PER form shows that he was regularly spoken to by police custody officers to check that he felt okay. At 5.01pm he left Thames Magistrates’ Court (where he had been remanded) en-route to Brixton prison. The PER form accompanied him there.
26. The man arrived at Brixton prison later that day. The process for a new prisoner at Brixton is that they are met by a senior officer (SO) in reception who checks the documentation which has accompanied them and books in their property. The prisoner is then searched and asked to sign for the property he is allowed to retain and for that which is stored. They are then taken to a holding room where they wait to be escorted to C wing, the wing for new prisoners. It is there that the prisoners are interviewed by a reception officer and a member of healthcare.

27. The reception officer who saw the man recalled interviewing him on the evening of 17 March. He could not remember how many new receptions arrived that night, but thought it was in the region of 30 to 60. He recalled that the man was given something to eat and drink before he interviewed him. The reception officer confirmed that at this interview an officer would have a prisoner's file in front of them which would include the PER form, however he would not have records from a previous time in custody. The officer could not remember which documents he had when he interviewed the man. (However, the officer indicated on the Cell Sharing Risk Assessment that he had received the man's PER, court warrant and pre-convictions.)
28. The reception officer remembered that the man had seemed okay, but apprehensive. He explained to the officer that he was on licence recall for common assault and breaking licence conditions by not staying at an agreed address. The reception officer said he was unaware that the man had actually been arrested for a sexual offence (as stated on the PER form and warrant). He said that the interview would have followed the same lines, although he might have offered the option of Rule 45 status if he knew about the sexual offence. The reception officer said that he could see the man had a lot of old cuts to his arms and the man said that he used to harm himself when he was younger. The officer asked if he had any thoughts or intention of harming himself again or in the future. The man replied that he did not. The reception officer asked him whether he had any suicidal thoughts and the man again repeated that he did not. The man said he just wanted to get his time in prison over and done with and be released.
29. A Cell Sharing Risk Assessment (CSRA) was also completed during this interview. On the CSRA, the officer wrote that the man was in custody for common assault, had abused alcohol or drugs and was currently dependent on drugs or alcohol. He had been on a 2052SH (the Prison Service's self harm and suicide document, which was later replaced by ACCT) previously, although was not at that time. The man told the reception officer that he did not want to share a cell with a drug user, that he used to self harm in his twenties but had no intention of doing so again. The man was assessed as being of medium risk to others and no concerns were noted.
30. The reception officer said that he explained the prison's Listener and Samaritans schemes and told the man that if he felt he needed to speak to someone, he could ask. Once the interview concluded, the reception officer took the man back to the holding cell and passed his file to a member of the healthcare team who was situated in the next room.
31. The acting head of healthcare who carried out the first reception health screen who saw the man was the prison's acting primary care manager. The acting head of healthcare carried out the First Reception Health Screen which determines a prisoner's general health or mental health concerns. She said that at this screening the member of healthcare staff might not have the prisoner's entire file but would have their basic details such as name, date of birth, and perhaps their holding warrant. She also said that sometimes she would see the accompanying PER form.

32. Due to the acting head of health care's absence from the prison, some seven months elapsed between the man's death and the interview for this investigation. She did not recall whether she had seen the PER form. However, on the front of the health screening form, she had written, under current charge 'sexual act/Bail Act/common assault', indicating that she must have been aware of the sexual offence he was charged with. The acting head of healthcare said that she would probably have interviewed the man about his depression and his medical problem, but would not delve far into the details of his offence.
33. The acting head of healthcare took details of his doctor she noted that he had been in prison before and the amount of alcohol, and frequency, that he drank. Question 13 of the screening form asks whether the prisoner might consider harming themselves and requires the member of healthcare to record their impression of the prisoner's behaviour and mental state. The acting head of healthcare ticked 'no' against whether the man would consider harming himself and ticked a box to indicate there was 'nil of note'. She agreed with the interviewer that, on reflection, it would have been useful to have noted that the man appeared to be withdrawing from alcohol.
34. The man confirmed that he had been treated by a psychiatrist outside of prison for anxiety and depression and gave details of a psychiatric hospital he stayed in for 11 days in 2007. The acting head of healthcare said in interview that she did not explore with the man the circumstances of his admission to psychiatric hospital the previous year. He also gave her details of the medication he had been prescribed for mental health problems which was sertraline and olanzipine.
35. The man told the her that he had tried to harm himself on 8 February 2008 by taking an overdose of a month's prescribed medication (although it is unclear whether these were anti-depressants or blood pressure tablets) and was admitted to Queen's Hospital. This was just over a month before he arrived at Brixton. She did not refer the man for a mental health assessment (contrary to current guidance) nor did she open an ACCT document. (Mental health referrals normally take place quite quickly, within two or three of days.) She recalled that the man said he did not want to harm himself at any stage but just wanted help for his alcoholism and his medication. She indicated that the man should be referred to the doctor regarding his physical health and for substance misuse, and also referred to the drugs service.
36. Although the acting head of healthcare knew about the man's mental health issues, recent overdose, the scars on his arms and his history of harming himself, and his substance misuse, she said that she used her judgement based on his responses to her questions. She said that he clearly stated that he had no intention of harming himself and that the overdose had been a "silly mistake". The acting head of healthcare completed the screening form by saying that the man was fit for normal location (on C wing for induction), for work and for single cell occupancy and that he had been referred to see the doctor.

37. The acting head of healthcare then completed the second part of the CSRA (begun by the reception officer who had interviewed the man). She told my investigator that the CSRA was used to determine whether a prisoner is a risk to another prisoner if they shared a cell. She agreed with the officer's assessment that the man was a 'medium' risk, meaning that he was no immediate risk to others but that the situation needed to be reviewed regularly.
38. The secondary health assessment is the second part of the health screening, which should be carried out one or two days after the first reception health screening. However, on this occasion, however, it was completed by the acting head of healthcare immediately after the first assessment. She explained that both assessments are carried out at the same time at Brixton. Nothing of note was recorded on the secondary health assessment, simply the man's weight and height, questions about smoking and cessation and hepatitis and other diseases.
39. The man then saw the prison doctor. The prison doctor noted that the man had Alcohol Dependency Syndrome. The man told the prison doctor that he was prescribed carbamazepine 600mg and sertraline 200mg and was unsure of his blood pressure medication. As these are high doses, the prison doctor needed to confirm the amounts with the man's community doctor and so asked healthcare to follow it up. The doctor prescribed one month's supply of atenolol 50mg to be taken daily, although it is not clear whether the medication was to be held in the man's possession or to be administered by a nurse. (The clinical reviewer wrote to the prison doctor on 31 December 2008. One of the questions he asked was what impression he gained from the man's history of taking carbamazepine and sertraline, especially in terms of a possible diagnosis, and in terms of any special precautions which he considered should be put in place in relation to the man's medical care. The prison doctor did not answer this question in his response of 28 January. The clinical reviewer also asked what information was available to the prison doctor when he saw the man. The prison doctor replied that he did not have access to any previous medical history, nor any screening documents.)
40. On a document entitled "Alcohol Detox Regime – High Dose" there is an entry to show that the man was given 40mg of chlordiazepoxide whilst in reception and a further 40mg the following morning. This is a librium detoxification regime - librium is a tranquilliser and can be used to prevent symptoms of alcohol withdrawal. It says underneath the medication '56x10mg+14x5mg, but it is unclear to what this refers. The man was also prescribed one month's supply of vitamin B strong compound and thiamine (B1 vitamin complex) 100mg, which he was permitted to keep in his possession.
41. There is a medication plan on the form as well which shows that the man was due to be given 40mg of chlordiazepoxide three times a day on 18 and 19 March, reducing to 35mg on 20 March and 30mg on 21 March. (This medication would be dispensed by healthcare staff.)

42. Following the healthcare assessment, the man was taken to his cell on C wing, the prison's induction wing, and allocated into a shared cell for the night. The man would have been given an opportunity to shower and to have an evening meal. The rest of the night appeared to pass quietly and there is no record on any prison documentation of his cell bell being pressed or any alarm being raised.
43. At some point during the morning of the incident, the man was seen by a nurse from the Substance Misuse Team. She only had available to her a list with the man's name and the substance he abused. He told the nurse that he had been free from alcohol for the last three days (since the day he was arrested). He spoke about his history of depression and the medication he had been taking. The nurse told my investigator that the man had seemed 'bright' and gave her no cause for concern.
44. The nurse from the Substance Misuse Team recorded on the Substance Misuse Clinical Assessment Form that had been at HMP Pentonville in 2007. He was not asked to give a urine sample as he was detoxing from alcohol. On the Substance Misuse Care Plan, the nurse advised the man about the detox programme, recommended that he should be given chlordiazepoxide as already prescribed by the prison doctor, and referred him to Duel Diagnosis, a team who deal with prisoners who have a history of mental health problems. (The man died before he was seen.)
45. By this time the man was alone in his cell, as his cell mate had been moved off of the induction wing earlier that morning. At around 10.00am he was collected from his cell to attend the wing's induction, held by the first officer on the scene.
46. The first officer on the scene told my investigator that induction is held for new prisoners who have not been at Brixton within the last three months. Prisoners attending the two day induction are unlocked at 10.00am. The aim is to familiarise them with the prison on their first day and to carry out an education assessment on the second day, when they are also told about housing and benefits. On the first morning, the first officer on the scene said they spoke to the prisoners about ACCT, Insiders and Listeners, adjudications, court appearances and telephone calls. They also explained how to use PIN phone, visits, having money sent in to them and how to buy canteen and their property.
47. The first officer on the scene recalled that the man sat at the front of the room during the induction, actively took part and asked for clarification about anything he was not clear about. He asked how much money he could spend a week on canteen and how he arrange for money to be sent in. At the end of the morning's induction, the officer explained that she would come to collect them for the afternoon session at around 2.30pm when that they would go through some other parts of the induction, including a visit to the library. The man asked whether he could take books out straight away and she replied that he could do so. The officer said that the man seemed to be interacting

quite normally and gave her no cause for concern. All the prisoners then returned to their cells for lunch at approximately 11.45am.

48. Lunch is served to prisoners in a bag, which they take back to their cells. The man would have collected his lunch between 11.45am and 12.30pm and then returned to his cell. He would then have been locked in until the second officer came to collect him for the afternoon's induction at 2.30pm.
49. During the morning the first nurse on the scene sent a fax to his doctor in the community, at the Harold Hill Healthcare Centre in Romford, to establish what medication he had prescribed to the man. A copy of the fax shows that the nurse sent the letter to the community doctor at 12.15pm. At 2.06pm the community doctor's surgery sent a faxed response. The community doctor confirmed that the man was transferred out of the practice on 5 March 2008 and was last issued medication on 30 January 2008 which included sertraline 200mgs daily, atenolol 50mgs daily and carbamazepine 500mgs a day.
50. After lunch, at approximately 2.00pm, the first nurse on the scene went to an afternoon briefing for staff. She collected up her induction list and began to go to the cells to call the prisoners for the afternoon induction. When she arrived at the man's cell she opened the door. Two cells are knocked into one with a separate toilet, and the door shut off from the main part of the cell. The first officer on the scene went into the main part of the cell and shouted for the man. She got no response and shut the door.
51. The first officer on the scene saw the second officer on the scene on the landing and asked him if he knew where the man was. The second officer on the scene replied that the man was in his cell. The first officer on the scene returned to the man's cell (it was now approximately 2.20pm) and looked through the observation panel which enabled her to see the toilet area. She could see the man's back and thought that he was looking out of the window into the exercise yard.
52. The first officer on the scene went into the cell and asked the man if he had heard her call out. There was no reply and she pulled open the toilet door and saw that the man had what appeared to be a sheet tied around his neck and his face was purple in colour. The first officer on the scene ran outside the cell and called the second officer on the scene and a third officer on the scene for assistance. (The first officer on the scene told my investigator that she had not asked for a radio when she started duty that morning, because she was working 'family friendly' hours and, by the time she arrived, there were usually no radios left.)
53. The second officer on the scene, who had been unlocking other prisoners on the landing, went inside the man's cell almost immediately after hearing the first officer on the scene's call. The second officer on the scene could see that the man was hanging from a ligature in the toilet area which he had attached to the bars of the window. The second officer on the scene was closely followed into the cell by the third officer on the scene.

54. The second officer on the scene used his anti-ligature knife (fish knife) to cut the ligature, whilst the first officer on the scene supported the man. The officers laid the man on the floor of the cell with his legs towards the toilet and his upper body towards the main cell area. The first officer on the scene recalled that the man's eyes were open and appeared to be glazed, his tongue was protruding and his face was a blueish colour. The second officer on the scene thought that the man looked as though he had already died. The third officer on the scene, who did not have a radio either, shouted out an emergency Code One call (the call means that a person is not breathing and alerts healthcare staff that they are required to attend immediately). The third officer on the scene did not hear the emergency call being put out over the radios, but within a few seconds members of staff from healthcare were at the cell. She then left the cell.
55. The SO was alerted to the emergency over his radio. A Code One call was put out, which alerts healthcare staff to a life threatening incident. The first nurse on the scene and the second nurse on the scene also heard the emergency call. The first nurse on the scene collected two bags of emergency equipment to take with her. One bag contained medication and the other bag held suction machines, oxygen, a mask and a defibrillator. (The first nurse on the scene took the bags from healthcare, she confirmed at interview that there is an emergency bag containing oxygen and a blood pressure machine on each wing.)
56. In the meantime, the second officer on the scene had checked the man for signs of life. He could not get a response, and so he and the first nurse on the scene commenced Cardio-Pulmonary Respiration (CPR). The second officer on the scene began chest compressions and the first nurse on the scene attempted to give mouth to mouth, using a face mask that she had with her, but she had difficulty putting the mask on the man as she had not used one before. The first officer on the scene said in interview that she did not have current first aid training. (They intended to work at a ratio of two breaths to every 15 chest compressions.) Before the first officer on the scene could apply the mask correctly, members of healthcare arrived.
57. The first nurse on the scene and the second nurse on the scene took approximately two minutes to get to the man's cell. A third nurse who also held a radio, was already in the cell. He was giving mouth to mouth resuscitation with the second officer on the scene still administering chest compressions, when the two nurses arrived. The second nurse on the scene recalled that at some point he took over the chest compressions. The acting head of healthcare, who also heard the call, arrived shortly afterwards.
58. The SO (a certified resuscitation trainer) was directed to C wing and then to the man's cell. He recalled that the man was lying on the floor with his legs in the toilet area and his upper body in the main part of the cell. He asked the nurses what checks they had made for signs of life and preceded to carry out his own. The SO checked that the man's airway was clear and felt for a pulse. No pulse was found so the nurses continued CPR. The SO took over chest compressions from the second officer on the scene and worked with the

third nurse. The first nurse took the oxygen and mask out of one of the emergency bags and passed them to the third nurse. By this time officers had left the cell to make room for the healthcare staff.

59. The SO applied the pads of the defibrillator to the man's chest. The machine instructed the SO to shock him. The SO explained during his interview that a defibrillator instructs a shock when heart movement is detected. The SO delivered a shock to the man and continued with CPR. However, the next reading two minutes later showed that the man was asystole (meaning there was no cardiac output). The SO said that the first reading might have been incorrect as a nurse may still have been touching the man (as opposed to standing clear). However, he could not be sure of this.
60. The SO took a bag valve mask from the emergency bag, to help administer breaths into the man. (This is a mask which is placed over the mouth and oxygen from the bag is administered by squeezing it.) The SO also inserted an oro-pharyngeal airway, which keeps an airway open down to the windpipe. The SO gave the man two breaths using the bag of oxygen. He noticed that, although the man's chest was not rising, his stomach was. (This can be an indication that a person's windpipe has been crushed whilst they were suspended. Air cannot pass into the lungs, but passes through to the oesophagus and into the stomach instead.) The SO stopped the breaths and continued with compressions only. At this point he noticed that the man was very pale, was cold to the touch and was cyanosed (a blue tinge to the skin which indicates a lack of oxygen in the blood). The SO used the defibrillator to assess whether the man should be shocked again, but this time no shock was advised.
61. A nurse (it is not clear which) palpated the man's abdomen (palpation is an examination technique) causing him to vomit. The SO had to use the suction unit to clear the man's throat from obstruction. CPR was continued, although The SO said he could tell that this was unsuccessful and he thought that the man had already died.
62. The acting head of healthcare recalled that staff continued to administer CPR until the paramedics arrived at 2.35pm. The paramedics checked the man for signs of life using their own equipment. After about ten minutes they decided that CPR was no longer advisable and left the cell.
63. The SO and the acting head of healthcare gathered up their equipment and the cell door was sealed at 2.41pm. The officers who had been on the scene and the first nurse on the scene went to the Governor's office suite to await a visit from a member of the Care Team and write an incident report. The Head of the Care Team, spoke to the staff who had been involved in the discovery and resuscitation of the man, but not the healthcare staff. (At that time, he was the only Care Team member at the prison so it was fortunate that he was on duty, although he was contactable on his mobile telephone in an emergency.) The second nurse on the scene went back to healthcare and the SO went off duty. The nurse who had done the first reception screen said that an informal de-brief was held in healthcare.

64. At 3.07pm the duty doctor arrived and pronounced that the man had died. The cell was re-sealed. In the meantime, staff tried to establish the man's next of kin details. There was no address on file, so the prison contacted the police for assistance. The man's daughter was located at 3.58pm.
65. A note was recovered from the cell and handed to the police when they arrived at the prison at 4.10pm. The note, written by the man but undated, said that he was innocent and could not live with people thinking he might "have done such a thing". He asked that his name be cleared as he was not guilty. At some point that afternoon the undertaker arrived to take the man to the mortuary, but my investigator could not find a record of what time this occurred.
66. Just after 4.00pm, the duty governor (who no longer works in the Prison Service) the family liaison officer, and the governor's secretary (who had experience of being with a care team at another prison) left Brixton to travel to the man's daughter's house. The family liaison officer told my investigator that he had held the family liaison role for almost two years and had attended a two day FLO training course. They did not telephone ahead to the man's daughter as the Governor's secretary said they did not have a number for her. (However, a mobile telephone number is recorded on the first page of the core record.)
67. The Governor's secretary said that they arrived at the house between 6.00pm and 6.30pm to break the news to the man's daughter. When the prison staff got there, she was not alone, but had her baby and her partner with her. The duty Governor and the family liaison officer explained that the man had died. The family liaison officer was unclear in interview about what information he actually provided. (When my investigator met with the man's daughter and her mother at their solicitors on 23 July 2008, she was told that staff did not seem to know much about what had happened and could not give her much detail. She said it would have been helpful if they had more information, ahead of their visit to her.)
68. The family liaison officer told my investigator that he had not given the man's daughter information regarding the prison's contribution to funeral costs because he did not want to overload her with information. It seems that she found out this information from the Coroner rather than the prison (and the prison reimbursed the cost some time after the man's family had to pay for the funeral in full). He did not pass on the details of the Coroner either, although he had this information. The family liaison officer was unaware of the requirement to maintain a Family Liaison Officer's Log. He was also unaware of a booklet produced by the Coroner about what to do when someone dies.
69. The family liaison officer gave the man's daughter his details and his mobile telephone number and took numbers for family members. However, the SO said during his interview that the family had some problems contacting him in the prison, as he was no longer authorised to carry a mobile telephone.

(Mobile telephones are no longer permitted in prison for any reason.) The man's family did have difficulty contacting the family liaison officer.

70. At 6.30pm a hot de-brief was held at the prison. (This is an opportunity for all the staff who were involved in the man's death to discuss what had happened and any issues arising as a result). It was chaired by the governor and attended, amongst others, by five governors, the SO, officers and nurses who had been on the scene. The governor explained that some of the staff who had been involved in the man's death had already gone home, but were spoken to before they left the prison.
71. One issue raised at the de-brief on behalf of the first officer on the scene, was that she had been unsure about how to use the breathing mask and highlighted this as a training issue. Another governor said that the paramedics had arrived 11 minutes after being called, although staff's perception was that it had seemed longer.
72. There is no record of a critical incident de-brief being held. (The de-brief should have been held a month or so after the man's death to give staff the opportunity to discuss what had happened and how they are feeling). The staff interviewed by my investigator did not receive an invitation to attend one. A member of the Care Team) said that he checked on staff the following day. He said that prisoners would have been reminded of the services of Listeners and Samaritans. The first officer on the scene said that a note explaining why the regime had been disrupted was circulated to prisoners. The third officer on the scene said that all prisoners who were on ACCTs were assessed and the second officer on the scene recalled that at least two prisoners had ACCTs opened for them because of their concerns after the man's death.
73. The second nurse on the scene said that nobody from the Care Team had contacted him at any time after the man had died, but that he had not contacted them either. He said he would have found it helpful to talk to a member.
74. Representatives from the prison did not attend the man's funeral, although The SO told my investigator that he offered to do so. A problem encountered by the family was the delay in receiving the man's belongings. There appeared to be some difficulty locating his property (although my investigator understands that it has now been returned to his family).
75. A post mortem was held on 2 April 2008 at Greenwich Public Mortuary which confirmed that the man died as a result of hanging.

ISSUES

Support for the man

76. Despite information about the man's vulnerability recorded on the PER form which accompanied him to Brixton, neither the reception officer nor the acting head of healthcare said that they noticed that he had been arrested for a sexual offence. Given that information and the additional comment on the PER that the man had made previous attempts on his life and suffered from depression, they should have considered providing additional care and support for him, which may well have included opening an ACCT.

The Governor and Head of Healthcare should issue urgent guidance to staff who meet a prisoner on reception, to follow the guidance in the first reception healthcare screening forms, in respect of mental health assessments.

77. I understand that an ACCT cannot and should not be opened for every new reception or for every prisoner charged with a sexual offence, but in the man's case I would have thought that there was enough information to suggest that he presented a risk to himself. I know that the man told staff that he had no thoughts of harming himself, but given the combination of his self harm history, the nature of his alleged offence,, his alcohol dependency, his withdrawal from alcohol and his depression, I believe that closer supervision would have been a sensible precaution.

The Governor and Head of Healthcare need to ensure that all staff are aware of all different types of triggers which may lead a prisoner to harm themselves, and of their responsibility to open ACCT's when necessary and to make referrals to the mental health service where appropriate.

78. I, of course, cannot say that if the man had been on an ACCT it would have prevented him from taking his life. Nevertheless it is essential that reception staff read and properly evaluate the information contained in the PER form.

The Governor should remind reception staff to read and properly evaluate the information in the PER form.

79. I also recommend that staff admitting a prisoner into reception or carrying out a health screening ensure they have as much documentation as possible with them when seeing the prisoner. The clinical reviewer also comments that more emphasis should be placed on the documentation containing a prisoner's past history, to enable informed decisions and less reliance on self reporting by prisoners.

The Governor and the Head of Healthcare should ensure that a system is in place so that staff in reception and those carrying out the health screening have all the relevant documents and past history about a prisoner whilst making their assessment.

Next of Kin details

80. The core record, which is also completed in reception, merely noted the man's daughter's name and telephone number as his next of kin details. This caused a delay while staff tried to obtain her address to allow the FLO to visit. The omission may have been because it was the only information the man knew or was willing to pass on. I make no recommendation here, but suggest that the Governor reminds staff of the need to obtain as much information at reception as possible.

Health screening

81. The acting head of healthcare carried out the man's first and secondary health screening at the same time. A secondary health screening should be conducted one or two days after the initial screening, to allow prisoners the time to adapt to their surroundings and raise any issues which they may not have considered when they first came to the prison.

The Governor and Head of Healthcare should ensure that a secondary health screening is carried out by healthcare one or two days after the initial health screening in reception. This should allow time for a prisoner to raise any issues of concern or difficulties they may have.

First aid training

82. The first officer on the scene and the second officer on the scene should be commended for their prompt actions after discovering the man, in releasing the ligature and in beginning resuscitation. However, none of the staff who arrived at the cell in the first instance had up to date first aid qualifications. Neither did they work to the new ratio of breaths to chest compressions which is 30 to two, rather than 15 to two. The first officer on the scene also said she did not know how to use the mask for administering mouth to mouth resuscitation. Prison training records show that only ten non-healthcare staff were currently first aid trained at the time of the man's death.

The Governor and Head of Healthcare should ensure that training needs of all discipline staff are reviewed, to include up-to-date first aid training and use of first aid equipment.

Family liaison

83. The prison's FLO, although trained and experienced in the role, did not appear to handle this case particularly well. According to the family, he was not fully apprised of the circumstances of the man's death before he visited them. He was unable to pass on important information regarding a contribution to the funeral expenses, the whereabouts of his property and arrangements for viewing the man at the mortuary. The FLO was also unaware of the need to complete a Family Liaison Log, which is an important document used by prison FLOs nationwide.

The Governor should ensure that prison FLOs are aware of current practice and provide full and accurate information for the bereaved family.

Care Team

84. At the time of the man's death there was only one official member of the Care Team. Fortunately he was contacted by mobile telephone and was able to come to the prison. My investigator was told that this situation had been remedied since then, and more members have now been trained and joined the Care Team.

Critical incident de-brief

85. A critical incident de-brief does not appear to have been held. It is important that staff who are involved in an event such as this are given continuing support and the opportunity to discuss what happened with others who may also have been affected. Whilst a hot de-brief (which did take place) is helpful in that it is held the same day, a critical incident de-brief is generally held a few weeks afterwards and gives staff time to consider what happened and how they are feeling.

The Governor should ensure that a critical incident de-brief is always held after a death in custody.

CONCLUSION

86. The man had been in prison before, but on this occasion he was charged with a sexual offence. The police had highlighted on the PER that, as well as the nature of his offence, he was at risk because he had a history of depression and of harming himself. The reception and healthcare staff who saw the man when he first arrived at Brixton both said they were unaware of his offence and believed he had been returned to prison as he had breached his bail. The nurse who did the first reception screen, however, must have been aware of the allegations against the man, as she recorded the charge on the front sheet of the First Reception Health Screen form.
87. Given the allegations against the man, his history of depression and his history of harming himself, I would have expected more care to have been taken when interviewing him in reception. Although staff have to accept what a prisoner tells them, and in this case the man said he had no intention of harming himself, there are other signs they must look out for, such as the scars on his forearms. I know that it is not possible for an ACCT to be opened for every new prisoner, and nor should it be, but I believe the combination of these factors should have alerted staff that the man may have been at risk of harming himself.
88. During his brief time at Brixton, the man seems to have been treated well. I was impressed with the induction arrangements and the speed with which healthcare confirmed his medication details. I am also pleased that the man's medication for alcohol withdrawal and blood pressure were started immediately. These are all examples of good practice.
89. I was also impressed by the action of staff who attempted to resuscitate the man. They worked professionally and calmly until the paramedics arrived and should be commended for this.

RECOMMENDATIONS

To the Governor and Head of Healthcare:

1. The Governor and Head of Healthcare need to ensure that all staff are aware of all different types of triggers which may lead a prisoner to harm themselves, and of their responsibility to open ACCT's when necessary and to make referrals to the mental health service where appropriate.
2. The Governor and Head of Healthcare should issue urgent guidance to staff who meet a prisoner on reception, to follow the guidance in the first reception healthcare screening forms, in respect of mental health assessments.
3. The Governor and the Head of Healthcare should ensure that a system is in place so that staff in reception and those carrying out the health screening have all the relevant documents and past history about a prisoner whilst making their assessment.
4. The Governor and Head of Healthcare should ensure that a secondary health screening is carried out by healthcare one or two days after the initial health screening in reception. This should allow time for a prisoner to raise any issues of concern or difficulties they may have.
5. The Governor and Head of Healthcare should ensure that a cross section of discipline officers have up to date first aid qualifications and are able to use first aid equipment such as face masks.

To the Governor:

1. The Governor should remind reception staff to read and properly evaluate the information in the PER form.
2. The Governor should ensure that prison FLOs are aware of current practice and provide full and accurate information for the bereaved family.
3. The Governor should ensure that a critical incident de-brief is always held after a death in custody.