

**Investigation into the circumstances surrounding the  
death of a man  
at HMYOI Brinsford in October 2009**

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

**September 2010**

This report considers the circumstances surrounding the death of a man at HMYOI Brinsford in October 2009. He was found hanging in his cell shortly after 6.00pm. He was 20 years old.

I offer my sincere condolences to the man's adoptive parents, his birth mother, his ex-girlfriend, staff at the hostel, and all those who knew him.

The investigation was conducted by an investigator and a colleague on my behalf. I would like to thank the governing Governors and the deputy governor for their openness during the investigation and their receptiveness to feedback at all stages. I also extend thanks to the liaison for the Ombudsman's office. In addition, I thank the clinical reviewer who conducted a review of the man's clinical care. She was appointed by the Primary Care Trust.

The man had served a number of custodial sentences in the past, some of them at Brinsford. After being sentenced on 2 June 2009, he was imprisoned at Brinsford until 5 August, when he was released. Having returned to custody on 20 October, he died just two days later. The members of staff who were involved with him did not think he was at risk. Only an hour before his death, he had a conversation with a senior officer and did not say anything that caused alarm or concern.

Since the Ombudsman began investigating deaths in custody in 2004, the office has had frequent cause to criticise the quality of communication across different areas of the criminal justice system, and indeed between departments in the same establishment. Sadly, I do so again here. A number of documents indicated the man's potential for self-harm and suicide, but they were not considered in conjunction with each other, or made available to the relevant departments. I make several recommendations in this regard.

This is the fourth apparently self-inflicted death at Brinsford since 2004. Only 15 weeks before the man's death, another young man died at Brinsford, in the same cell and using the same method. I have paid close attention to the issue of bunk beds in single cell accommodation, which was an important factor in both cases.

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.

**Jane Webb**  
**Acting Prisons and Probation Ombudsman**

**September 2010**

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## SUMMARY

The man began a 16 week sentence of imprisonment at HMYOI Brinsford on 2 June 2009. He had served a number of previous custodial sentences, some of them at Brinsford.

When he arrived at Brinsford, an initial health screening noted that he suffered from attention deficit hyperactivity disorder (ADHD), and had self-harmed four years previously. An assessment of any risks by sharing a cell was carried out, but did not highlight any issues.

He spent the night of 2 June in Brinsford's dedicated first night centre. He was moved to the induction unit the following day. On 6 June, he transferred to one of Brinsford's standard residential units. He was located in a double cell with a young man whom he knew.

The man's custodial documents indicate that he had a somewhat unsettled time at Brinsford. He spent the night of 10 June back in the first night centre due to "poor coping issues", and on 24 June was involved in a fight with another young offender. On 30 June, he refused to attend his education class, and on 9 July he was assaulted in the servery area of the unit.

After refusing to attend education again on 27 July, he was moved to a different unit two days later because of "problems with peers". By this point, he had spent time on three different units (as well as the first night centre and induction unit) and had been moved each time because of issues with other young offenders. A prison officer wrote in the wing history file that, whilst he did not cause serious discipline problems, he needed to improve his attitude.

The man was released from Brinsford on 5 August and subject to licence conditions. He lived in a hostel in Newtown after a referral from his probation officer. He had lived in the same hostel on a number of previous occasions and was very familiar with the members of staff there. The hostel manager found him lively and talkative, but noticed changes in his behaviour around September and October. He became more subdued and spent less time talking to the hostel staff.

On 17 October, the man visited his parents at their home. It was the last time they saw him. He was arrested on 19 October and kept in police cells overnight. During this period of detention, police officers noticed that he seemed to be under the influence of illicit drugs. Worried about his condition, they requested an ambulance. He was taken to hospital under police escort in the early hours of 20 October. He admitted to taking substantial quantities of ecstasy and cocaine.

He was monitored in hospital overnight and discharged at 9.30am on 20 October. He returned to police custody and, later the same day, was taken to the Magistrates' Court. His escort record listed the hospital discharge summary as an additional included document. During his time at court, he was interviewed by a community psychiatric nurse (CPN), who completed a mental health assessment. The nurse noted that he would be at increased risk of self-harm or suicide if he were given a custodial sentence.

The man was sentenced to nine weeks' imprisonment, and returned to Brinsford. The senior officer in the reception area signed the escort record, but was unable to recall if the hospital discharge summary arrived. In any case, medical documents would be given to the member of healthcare staff completing the initial health screening without being opened. His warrant of imprisonment carried a warning about him posing a risk of self-harm or suicide.

The initial health screening, completed shortly after his arrival at Brinsford on the evening of 20 October, made passing reference to a discharge summary. There was no further elaboration or clarification, and it seems that no action was taken in response to the document. He spent the night of 20 October in the first night centre. At 9.33pm he made two telephone calls to his ex-girlfriend.

On 21 October, the man moved to the induction unit. On the same day, the CPN's report was faxed by the Magistrates' Court to Brinsford's reception area. A copy of the report was placed in his core custodial record, but it does not seem to have been made available to clinical staff. He was seen for a secondary health screening, and no further issues were raised.

The man moved to G wing on 22 October. He had been released from Brinsford only 11 weeks earlier and so a full induction was not considered necessary. At 4.13pm, he made a short telephone call to his ex-girlfriend, and shortly after 5.00pm collected his evening meal. At this time, he had a conversation with the unit's senior officer, who recalled that he appeared the same as usual. The senior officer and another officer who saw him had no cause for concern. After collecting their meals, all of the young men on the unit, including the man, were locked in their cells.

Shortly after 6.00pm, officers unlocking cells to allow prisoners access to the gym found the man hanging from a ligature attached to his bunk bed. Two prison officers started cardio-pulmonary resuscitation (CPR) very quickly, and healthcare staff continued upon their arrival. Despite continuous and uninterrupted efforts until a paramedic arrived, he could not be resuscitated. He was pronounced dead by a paramedic at 6.34pm.

I have investigated issues around communication, information sharing, and the use of additional documents that arrived. I have also covered the issue of bunk beds in cells that are used for sole occupancy. Additionally, I have addressed the subject of access to medical equipment, staff training, matters raised by Brinsford's critical incident debrief, and issues raised by the family. I make ten recommendations and endorse a further two recommendations from the clinical reviewer.

## THE INVESTIGATION PROCESS

1. One of the Ombudsman's senior investigators opened the investigation on 22 October and had a lengthy telephone conversation with the Governor (then the governing Governor) the same day. The investigator then visited Brinsford on 9 November and met with the PPO's liaison officer. The liaison officer facilitated access to all of the documentation relating to the man's time in custody. The family liaison officer was not available, but the investigator was able to access the family liaison log. He also met with the deputy governor.
2. The liaison officer and the Governor explained to the investigator that the man had been in Brinsford for only a short time prior to his death, but had served a number of previous custodial sentences and was very familiar with the regime. During his two days at Brinsford, nobody had expressed any cause for concern about him, and his death had come as a shock, particularly for members of staff who had seen him only a short time beforehand. They were aware that, shortly before his arrival at Brinsford, he had been admitted to hospital as a result of a suspected drugs overdose, but said this information had only come to light after his death.
3. One of the Ombudsman's family liaison officers (FLOs) contacted the man's adoptive parents. They welcomed a visit to discuss their concerns regarding his time in custody and the circumstances of his death. As such, the FLO and the investigator met with the man's parents at their home on 19 January 2010. They talked extensively about their experience of adopting him and their lives with him during his formative years. Regarding the circumstances of his death, his parents had the following concerns and questions:
  - He was seen by a community psychiatric nurse (CPN) when in police custody, before he was transferred to Brinsford. A report from the CPN had supposedly been faxed to Brinsford on 21 October. Was this report actually sent, and if so, was it acted upon?
  - If staff at Brinsford were aware of concerns relating to self-harm and suicide, why was he allowed a single cell?
  - What was the content of the telephone calls between him and his ex-girlfriend, shortly before his death?
  - Was he at Brinsford when the previous death occurred there?
  - What is Brinsford's policy regarding drugs and alcohol withdrawal and detoxification? In particular, what procedures are put in place for young offenders thought to be under the influence of drugs upon arrival?
4. The FLO also contacted the man's birth mother. She was keen to discuss her concerns, and the FLO and the investigator met her at her home on 19 January. She asked the following questions about his time in custody and the circumstances of his death:
  - Were staff at Brinsford aware of his attention deficit hyperactivity disorder (ADHD)? If so, was he subject to suicide watch?

- What was the content of the telephone calls between him and his ex-girlfriend, shortly before his death?
  - What was the content of the note that he left in his cell before his death?
5. Where the family's questions come within the Ombudsman's Terms of Reference, I do my best to answer them in my report.
  6. The FLO contacted the man's ex-girlfriend. She did not feel that a visit was necessary. The FLO also spoke by telephone to the manager of the hostel where the man lived between August and October 2009.
  7. The above parties each received a copy of my draft report. Concerns regarding the failure to locate the man's paperwork and his location in a single cell were reiterated. However, those who provided feedback were, for the most part, in agreement with the findings of the report and the subsequent recommendations to improve practice in these areas.
  8. The investigator returned to Brinsford in January 2010, accompanied by another senior investigator to interview members of staff about the man's time in the custody and the circumstances of his death. They interviewed eight members of staff. The investigator interviewed a further three members of staff in February. On 10 February, he met with a Detective Sergeant (DS) from Staffordshire Police. The investigator took copies of paperwork held by the police, including statements from staff at Brinsford, the paramedic's patient report form, and a written assessment of the man made by a community psychiatric nurse (CPN). He also discussed the police investigation with the DS and took a copy of his report.
  9. The local Primary Care Trust (PCT) appointed a senior clinical governance manager to conduct a review of the man's clinical care whilst in custody. (The purpose of a clinical review is to examine the medical care that a prisoner received whilst in custody, which should be of an equivalent standard to what might have been expected in the community.) She consulted his medical records from his time at Brinsford, as well as his GP records, a report prepared by a community psychiatric nurse (CPN), and records relating to hospital admission. Her findings are summarised in this report and the full clinical review is included as an annex.

## **HMYOI BRINSFORD**

### **General**

10. Brinsford is a young offender institution (YOI) near Wolverhampton. It has a maximum operational capacity of 569, and holds remanded, unsentenced and convicted young adults aged between 18 and 21 years. At the time of the man's death, the YOI also held young people aged between 15 and 17. All these young people have since been moved to other establishments and the space will be used to accommodate young adults.
11. Young offenders arriving at Brinsford spend their first night in a dedicated first night centre, and then up to a week on a separate induction unit. They are then moved to one of five other residential units. (The young people's residential unit will become available for young adults from April 2010.) There are wings to accommodate remand and unsentenced young men, foreign nationals, and those with enhanced status. A separate healthcare centre is able to accommodate in-patients.
12. Primary healthcare services at Brinsford are provided by the local Primary Care Trust (PCT). Contracts with a local GP practice mean a doctor is available in the YOI on every weekday and on Sundays, with an on-call service at other times. The healthcare centre caters primarily for young offenders with mental health concerns. A mental health in-reach team is provided by the PCT.

### **Performance**

13. The Ministry of Justice produces quarterly performance figures for all prisons in England and Wales. Every establishment is given a rating between 1 and 4 based on 34 agreed performance indicators. The most recent figures available at the time of writing are for quarter 2 of 2009-2010 (July, August and September 2009). For this period, Brinsford received a rating of 3, indicating good performance (the maximum score of 4 indicates exceptional performance).
14. HM Chief Inspector of Prisons inspected Brinsford in November 2009, though her report had not been published at the time of writing. The most recently published report about Brinsford concerns an unannounced inspection in 2007, following the previous full inspection in 2005. She found that Brinsford was "still not sufficiently safe" and had not made enough progress since her last inspection. Many areas of the YOI required improvement, including the reception, first night and induction processes. The issue of reception is pertinent to this case and is discussed in the body of my report.
15. The most recent report issued by the Independent Monitoring Board (IMB) at Brinsford covers the period from July 2008 to June 2009. The report identified a number of issues but also stated that "Brinsford maintains a positive atmosphere and we cannot speak highly enough of the majority of staff and

managers in creating an environment characterised by care and encouragement”.

### **Previous deaths at HMYOI Brinsford**

16. The Ombudsman’s office has been responsible for investigating deaths in custody since April 2004. Prior to the man’s death, three other apparently self-inflicted deaths have been investigated. One occurred in 2005, the second in 2007, and the last in July 2009, only 15 weeks before his death.
17. The investigation into the death at Brinsford in 2007 highlighted an issue around staff care in the immediate aftermath. I cover the same subject in this report. The death in July 2009 remains under investigation, although the investigator has liaised with the investigator of that case regarding similarities. Both deaths were due to hanging; both took place in the very same cell and used the same ligature point. This report discusses the issue of ligature points that was raised following the death in July 2009, and the action that has been taken by Brinsford following the man’s death.

## KEY FINDINGS

18. The man appeared at Magistrates' Court on 20 May 2009 and was remanded to HMP Parc. On 2 June, he was sentenced to 16 weeks' imprisonment and transferred to HMYOI Brinsford.
19. An initial health screening at Brinsford was completed at 7.30pm on 2 June by Nurse A. A note was made in the man's clinical record that he had harmed himself four years previously, but during the interview denied any intention to do so again. It was also noted that he suffered from attention deficit hyperactivity disorder (ADHD) but was not taking any medication. Although the nurse wrote that the man would be referred to the primary health team for assessments due to his ADHD, it is not clear if any such appointments took place as there are no further entries in his medical record.
20. The cell sharing risk assessment (CSRA), a tool to identify any risks associated with prisoners sharing a cell, was completed. The nurse wrote that the man would not mind sharing a cell. She also noted, as she did in the clinical record, that he had self-harmed four years previously. No further details were given.
21. The man was taken from the reception area to the Induction and Throughcare Support Unit (ITSU). The unit's name is outdated, as the bulk of the induction process is carried out elsewhere. The ITSU is used as a first night centre, where young offenders usually spend at least one night before moving to the induction unit for up to a week. He spent his first night on the ITSU, and on the following day, 3 June, he moved to the induction unit. On 6 June, he moved to G wing, part of Residential Unit 3. This unit usually holds unsentenced young adults who are awaiting sentence, though it can also hold sentenced prisoners if they present control issues or if there are general population pressures. He was placed in a double cell with a young man whom he knew.
22. On 11 June, Senior Officer (SO) A wrote the following in the man's wing history record:

"The man was located in the ITSU last night due to poor coping issues. The last time he was at Brinsford (May 2009) he accrued some debt from loaning tobacco. He is currently serving a sentence, so should be on Residential 2 anyway. He only came on to Residential 3 due to a need for space on Residential 4."
23. The man was moved to B wing on Residential Unit 2, and seems to have had an unsettled time there. On 24 June, he fought with another young offender and, on 30 June, he refused to attend education. On 9 July, he was assaulted by another young man at the servery area. An entry was made in his wing history file about this incident, but there is no detail as to the severity of the assault or any injuries that he might have sustained. There is no indication in his medical record that he was treated by healthcare staff.

24. On 20 July, the man's personal officer (a named officer for young offenders to approach with queries, problems and concerns), wrote the following in his wing history record:

"The man is still located on B1 landing and from my observations is very immature in his attitude and behaviour. He demonstrates a poor appearance and cell standards whilst on the landing. Advised accordingly."
25. The man refused to go to education again on 27 July. Two days later, he was moved to D wing, a different area of Residential Unit 4, because of what Officer A described in the wing history record as "problems with peers". The nature of these problems was not elaborated upon.
26. On 2 August, the man's shadow personal officer wrote the following:

"The man has been quiet since moving to D wing and has not attended any wing association. He is not so much a discipline problem but his attitude needs improving."
27. Three days later, on 5 August, the man was released from Brinsford. As is normal practice, he had served half of his sentence in custody, and would be subject to licence conditions until his sentence end date of 4 November.
28. During his time in the community, the man lived at a hostel which provides emergency, temporary accommodation after receiving referrals from the homelessness team at the County Council. The investigator spoke to a senior probation officer at the probation office who confirmed that his offender manager (a probation officer responsible for his supervision in the community) had made a referral to the homelessness team prior to his release from Brinsford.
29. The investigator spoke to the team leader at the hostel by telephone on 19 February 2010. He and his staff were very familiar with the man, who had stayed there on four previous occasions over the preceding few years. He acknowledged that he could be difficult to manage at times, but said he had good and bad days, and had an honest and close relationship with the hostel staff. The team leader said the man was usually quite outgoing and would regularly spend up to an hour in his office talking to him.
30. The man appeared at Magistrates' Court on 19 September for a further offence. Although he was still subject to licence conditions, he was not recalled to custody and was instead sentenced to a two month curfew. As a result, he was electronically tagged.
31. The team leader said that he and other members of the staff noticed changes in the man's behaviour in the weeks leading up to his recall to custody. He stopped visiting the office to chat, and became much more subdued than usual. He recalled that the man was in a relationship, which was a source of

support in one way, but which also led to feelings of jealousy and insecurity on the man's part. The team leader also suspected that he was using illegal drugs. He started to have disputes with other people on the premises, and the team leader became worried about his mental health.

32. The man visited his adoptive parents at their home on the evening of 17 October. He appeared dishevelled and confused, and his mother suspected he had been using drugs. He told his parents that he had dislocated his shoulder and had used morphine for pain relief. He had to be back at the hostel for his curfew time of 7.00pm, and was driven to the station by his father.
33. On 19 October at 5.50pm, the man was arrested at the hostel on suspicion of theft, and was taken to a police station. The custody officer noted on the custody record that he appeared to be uninjured and sober. He was asked questions about his health and welfare, and his answers gave no cause for concern. However, the custody officer decided to place him in a monitored cell. He had experience of him from previous arrests, and thought he seemed more subdued than on previous occasions.
34. At 11.48pm on the same evening, the custody officer and another police officer spoke to the man to explain that bail would be refused and he would appear in court the following day. The custody officer noted that although he seemed to understand what was being said, he also appeared confused. He refused all food and drink whilst he was at the police station. Shortly after midnight, the custody officer increased the frequency at which he would be monitored to every half hour. At 12.42am on 20 October, he was checked and found to be red around the eyes, and sweating. The custody officer suspected that he might be under the influence of drugs. The man spoke to a police doctor by telephone, who advised that he should be taken to hospital for a blood test.
35. The man was taken to the hospital by ambulance. The paramedics told the police officers that he had disclosed taking eight ecstasy tablets the previous day. He arrived at the hospital at 2.33am on 20 October. At 4.41am, hospital staff told police officers that he also admitted to taking crack cocaine. He was moved to the medical assessment unit at 5.00am, and monitored there before being discharged at 9.30am. The discharge summary was brief but stated that he had been admitted to hospital "following an overdose of ecstasy plus crack and cocaine". He arrived back at the police station at 10.20am.
36. Shortly before midday, the man left the police station and was taken to Magistrates' Court. A note was made on his escort record that hospital discharge papers were included. He arrived at 12.25pm. Ten minutes later, he was seen by a community psychiatric nurse (CPN) who completed a mental health assessment. This was a brief meeting, lasting ten minutes. He wrote the following on the assessment form:

"When he was last imprisoned the man made cuts to his wrists about 12 months ago. He denies any self-harming intention at present. He states that he has not considered suicide."

37. The CPN noted that the man had been taken to hospital and wrote that he had denied that his use of illicit drugs was an attempt to kill himself. In terms of recommendations, he wrote the following:
- “If the man is imprisoned I consider that risk of self-harm or suicide will increase and that this information should be communicated to the prison in-reach team by probation services.”
38. Shortly before 5.00pm, the man was sentenced to nine weeks in custody. He was abusive to the court staff and smeared excrement on the cell walls and spy-hole. At 6.55pm he left the court and was transferred to Brinsford, arriving at 8.05pm.
39. The Ombudsman’s investigator spent an evening in the reception area at Brinsford, observing the process of young offenders arriving at the establishment and talking to members of staff about the procedures involved. When an escort vehicle arrives, the escorting staff member produces the paperwork and property relating to the young men on the vehicle. This is processed by a senior officer and another prison officer. The young offenders then enter the establishment individually and unrestrained, with returning offenders usually going in first. Following a conversation with the senior officer, the young men wait for a short time in a holding room. Each person is provided with a meal and then seen individually by a number of people for various reasons. A prison officer logs the young offender’s property, and a member of the healthcare team sees him for an initial healthcare screening. The CSRA is completed, and the young offender is taken to the first night centre.
40. When the man arrived at Brinsford, he was met by SO B based in the reception area. He explained during interview with the investigator on 10 February 2010 that the reception area is staffed by a senior officer and four prison officers, and these staffing levels remain until all young offenders have arrived, regardless of the time. He did not specifically recall the man’s arrival at Brinsford, and so was unable to say for certain whether the hospital discharge paperwork arrived with him. However, he said that he would usually check that the escort record was correct, and would ask for it to be amended should it specify documents or property that did not arrive. He thought that, because he had signed the form, it was safe to assume that the discharge paperwork arrived with the man.
41. SO B went on to say that if medical information arrived with a young offender, this would usually be in a sealed envelope. He said he would not open it due to the confidential nature of its contents. It would be handed, unopened, to the member of healthcare staff completing the initial health screening. He said that the healthcare staff member would normally alert the reception staff if medical documents contained information that was relevant to them.
42. The initial health screening in this case was completed by a healthcare assistant. He told the investigator that the initial screening covers a range of

topics and is completed on the NHS computer system, known as System One. He said that the time taken to complete the screening varies based on the needs of the patient. He remembered the man arriving at Brinsford and said he was withdrawn throughout the interview. When he asked him about his demeanour, he said it was his first time in custody and that he was scared of the unknown. (This was, of course, not the case. He had served a number of previous custodial sentences, but the healthcare assistant recalls him saying it was his first.) He did not have specific concerns about him in terms of self-harm or suicide. He said in interview that many young offenders who arrive can present as quite withdrawn due to the prospect of serving a custodial term. He recorded that the man told him about recently dislocating his shoulder.

43. When asked by the investigator about any additional documents that might have arrived with the man, the healthcare assistant said he did not recall anything of that nature. He said that nothing was passed to him by any member of staff during the reception process. He relied on his observations of the man, and the answers to his questions, when completing the initial health screening.
44. One of the questions on the System One computer system asks about “health information received from [an] outside source”. The healthcare assistant made reference to a “discharge summary of medicines for patient” but did not elaborate further on this. When the investigator asked him about this information, he said that prisoners received from a hospital would usually have a discharge summary. He could not specifically recall seeing such a document in the man’s case, but remembered that he had said he had recently dislocated his shoulder, and so thought the discharge summary could relate to this matter.
45. The cell sharing risk assessment (CSRA) is also completed in the reception area. The primary purpose of the CSRA is to identify issues around cell sharing, and the first two sections of the form are completed by a prison officer. In the man’s case, Officer B was the officer who completed the form. He said that the form is completed privately with the young offender. It provides a good opportunity for him to disclose any general concerns about being in custody, and any issues of self-harm or suicide. He could not specifically remember the assessment form that he completed with him, but said the forms are completed primarily on the basis of information given by the young man. Although the man had spent time in hospital earlier that day after suspected illicit drug use, he answered no when asked if he had ever abused, or been dependent on, drugs or alcohol.
46. Officer B wrote on the form that the man “does not wish to share a cell, states he would get depressed”. During interview with the investigator, the officer said it was not unusual for young offenders to be reluctant to share a cell, and this by itself would not necessarily be reason for concern about self-harm. He assessed him as a medium risk regarding cell sharing, indicating that there was no immediate risk but that the situation would need to be reviewed regularly.

47. The third section of the CSRA is completed by a member of healthcare staff, who in this case was the healthcare assistant. He also indicated that the man was “not happy to share a cell” and echoed Officer B’s sentiments that this was not necessarily a cause for alarm. The healthcare assistant said that many young men are reluctant to share a cell, for a variety of reasons. He also assessed him as a medium risk in terms of cell sharing, and answered no to the question of whether any concerns had been raised following the self-harm assessment.
48. A document that would have arrived with the man is the warrant ordering his imprisonment. The investigator observed that the warrant was one of the first documents checked by the reception staff, in order to ensure that the correct person had been received and that their detention was authorised. The man’s warrant had a typed, emboldened note at the bottom of the page, which read: “NB Please note the defendant is vulnerable and volatile and likely to be prone to self-harm”. There is no evidence to suggest that this note was considered at any point during the reception process. There is no reference in the CSRA or the initial health screening to an increased risk of suicide or self-harm.
49. The man was taken to the ITSU (the first night centre), where a ‘young adult initial reception assessment’ was completed by a prison officer based on the unit, at 9.30pm. The assessment is also completed largely on the basis of the prisoner’s own report. Officer C noted that the man had no history of self-harm and had never been diagnosed with a mental or physical health problem. He also indicated that he did not have an immediate cause for concern after interviewing him.
50. In his statement to Staffordshire Police, Officer C said that prior to interviewing the man he knew that he was irate and agitated because he had been located in a shared cell against his wishes. A single cell had been found before the interview, and Officer C recalled that he was quite relaxed by the time the interview started. In terms of his presentation and demeanour during the interview, Officer C said he had no cause for concern. He was aware that he had previously been subject to the Assessment, Care in Custody and Teamwork (ACCT) process, which is used for prisoners thought to be at risk of suicide and self-harm, but believed this was due to vulnerability rather than because of an act of or intention to self-harm. The man was familiar with the procedures at Brinsford, having served several previous sentences there, and so the interview was not as long as it might have been for a completely new young offender. Officer C estimated that he was with him for 15 to 20 minutes, which he described as typical for a young man coming back into custody.
51. All telephone calls made by prisoners at Brinsford are recorded, although they are not usually monitored as they happen. Following the man’s death, the investigator obtained a list of his telephone calls and transcripts of the conversations. At 9.33pm on 20 October, he made a telephone call and left a voicemail message saying he hoped that when he was released he would be

able to “sort things out” with the message’s recipient. One minute later, he made a short call to the same number, and spoke with someone believed to be his ex-girlfriend. She shouted throughout the call, appeared angry with him, and referred to an altercation between him and her current partner. Very shortly after this call, he telephoned her again, and a very similar conversation followed.

52. The man spent the night of 20 October in the ITSU, and no concerns were raised about his well-being. The following day he was seen by a nurse based at Brinsford for a secondary health screening. This is a follow-up to the initial health screening and is usually completed within 24 hours of a young offender’s arrival. Nurse B saw him at 11.00am. In her statement to police, she said the interview took around 30 minutes. She remembered that he was rude and answered her questions reluctantly. Nurse B said he did not present in a way that gave her any concerns about suicide or self-harm and that, if he had, she would have noted it on the computerised record of the interview. She explained that his previous medical records were not available during the interview, and so it was based primarily on his own comments. As there were no concerns or medical issues raised, she did not refer him for an appointment with a doctor.
53. Nurse B recalled the man saying he was in a very supportive relationship. Whilst this does not seem to be the case based on the telephone calls that he made the previous evening, she would not have had any knowledge of those conversations.
54. Neither the healthcare assistant nor Nurse B specifically referred to making an appointment for the man with a doctor. However, a note in his clinical record says he failed to attend such an appointment on 21 October. The appointment may have been made because he reported that he had recently dislocated his shoulder, but as the entry in the clinical record did not provide any further information, it is impossible to be certain about this matter.
55. On the same day, 21 October, the man moved to the induction unit. Officer D wrote in his wing history file that he was “fully versed with life at Brinsford so recommend fast track induction”. Whilst new young offenders usually spend around one week on the induction unit, those who have transferred from another establishment or those who have been released from Brinsford less than six months previously can be subject to fast-tracking if this is thought appropriate.
56. At 12.30pm, the Magistrates’ Court faxed the written assessment, which had been completed the previous day by the CPN, to the reception area at Brinsford. It is unclear who collected this fax, but it was placed in the man’s core record. A copy was not found in his medical record, and there is no evidence to suggest that the healthcare department was made aware of the document’s existence. Other than being placed in his core record, there is nothing to suggest that it was acted upon or followed up in any way.

57. Although he would not be spending a week on the induction unit, the man remained there overnight on 21 October. No concerns were raised about his well-being. In view of the decision that he would be fast-tracked, he was moved to G2 landing, on Residential Unit 3, on 22 October.
58. At 4.13pm, the man made a 58-second telephone call to his ex-girlfriend. She asked him why he was calling and he said he needed to talk to her. He explained that he did not want to talk about anything in particular, but needed a chat. He said he thought nobody wanted to talk to him, and towards the end of the call, said, "It's just like no-one would miss me, would they?" His ex-girlfriend responded, "No," and, after around five seconds of silence, he ended the call.
59. The regime at Brinsford involves young offenders being unlocked to collect their evening meal between 5.00pm and 5.30pm. They then return to their cells to eat their meals, whilst members of staff have a meal break between 5.30pm and 6.00pm. At 6.00pm, young offenders are again unlocked for either association or a gym session, depending on the day of the week.
60. A prison officer based on G wing unlocked the man's cell at around 5.00pm. During interview with the investigator on 22 January 2010, Officer E said the man did not appear low in mood, and there was nothing to suggest a cause for concern. Senior Officer A recalled during interview on 21 January 2010 that he saw him after he was unlocked to collect his evening meal, and this was the first time he realised that he had returned to Brinsford. He said:
- "I spoke to him and I said, as we do, 'Back in again?' and he was talking with me, I can't remember specifically what he was talking about. But he was in good spirits, he was quite jovial, you know because he recognised me as well, and we had a bit of banter and he was fine."
61. The man returned to his cell with his meal as planned. Shortly before 6.00pm, a physical education instructor (PEI) arrived on the unit. On this particular day, the young offenders on G wing were due to be unlocked and taken to the gym. SO A, Officer E and the PEI recalled during interview with the investigator that they began to unlock the cells at almost exactly 6.00pm. SO A and Officer E both said that G2 landing (where the man was located) was the first to be unlocked.
62. Officer E told the investigator that he unlocked around three cells before he arrived at the man's. He opened the observation panel but was not able to see him in the cell because it was too dark. He opened the cell door, and as light from the landing entered the cell, saw him suspended by a ligature attached to the top bunk of the cell's bunk beds. He shouted to SO A for assistance, then used his radio to relay an urgent message asking healthcare staff to attend.
63. SO A recalled the events slightly differently, saying that Officer E only opened the cell when he arrived. Nevertheless, the SO was on the same landing and

arrived within a few seconds. He and Officer E took the man's weight, and Officer E used his anti-ligature knife to cut the ligature.

64. The PEI was on the same landing, but did not hear Officer E shout for assistance. He was first alerted that something was wrong when he heard a message over the radio saying that a discipline alarm had been activated on the G2 landing. The PEI ran to the cell to find SO A and Officer E in the process of cutting the man down.
65. The communications room log states that the urgent message from Officer E was received at 6.09pm. The communications room was informed that this was a 'code blue' emergency (a designated radio call sign to indicate breathing difficulties or asphyxiation). The same log indicates that an ambulance was called at 6.13pm.
66. SO A and Officer E laid the man on his back on the floor of the cell. The PEI said that a few young men had been allowed out of their cells before the man and were in the immediate vicinity of his cell. He decided to lock them in the landing television room temporarily in order to clear the area.
67. An officer in the central association area of Residential Unit 3, an officer in the kitchen of Residential Unit 4, and an officer on F wing, part of Residential Unit 4, all made their way to the G2 landing immediately after hearing the call for assistance over the radio. Their recollections of the time at which the radio message was received were consistent. The first two officers arrived first, very shortly after the man had been cut down. Officer F said that when he arrived, he checked for signs of life with SO A, and then he and Officer G began cardio-pulmonary resuscitation (CPR). The man had recently eaten and so there was a significant amount of food matter around his mouth. Officer F did not have a mouth guard, though one was found within seconds. Officer G performed chest compressions, with Officer F administering breaths.
68. When Officer H arrived at the man's cell, CPR was already underway. Almost as soon as she arrived, members of staff were made aware of another medical emergency (also a 'code blue' situation) on Residential Unit 2. Officer H explained during interview that she thought there were enough members of staff attending to the man, particularly as CPR had commenced. She made her way to Residential Unit 2 to see if she could be of assistance with the second medical emergency.
69. A registered general nurse (RGN) was in the healthcare department at the time of the initial radio message about the man. A nurse who was registered as a mental health nurse (RMN) from the day in question, but was employed as a healthcare assistant at the time, was also based on the unit. Both members of staff remembered receiving the radio message at approximately 6.00pm. The RGN said that, immediately after the initial message, she asked for clarification of the incident type and was told it was a 'code blue'. This alerted her to the fact that she would need to take a defibrillator to G2 landing as well as the standard emergency bag.

70. Both nurses immediately went to the treatment room in the healthcare department where the emergency equipment was located and, after collecting the bag and defibrillator, ran to G2 landing. Both nurses estimated in interview that it took them around two minutes to reach the landing.
71. When they reached G2, both nurses recalled that two officers were performing CPR. One of the officers was administering chest compressions, whilst the other administered breaths. The RGN took over the breaths, using a resuscitation bag attached to an oxygen tank. The RMN attached the defibrillator and then took over chest compressions. The defibrillator advised that there was no heart rhythm and as such, no shock was advised. Manual CPR continued.
72. Officer H arrived back at the cell after leaving to attend to the incident on Residential Unit 2. She took over chest compressions to avoid other members of staff becoming too tired to perform them effectively. The PEI helped the RGN to administer breaths using the resuscitation bag. However, he recalled during interview that this was very difficult because the man's airway was completely blocked with food matter. However, the CPR continued.
73. The rapid response paramedic recorded on the patient report form that he was mobilised at 6.13pm and arrived at Brinsford at 6.22pm. This timing is consistent within five minutes to Brinsford's communications log, which reports that the paramedic arrived at 6.27pm. Officer F, having been involved in the previous death at Brinsford, had made his way to one of the wing's entrances where he knew the paramedic would arrive. He did not recall being instructed to do this, but remembered from the events of three months previously that the paramedic would need to gain access to the wing. He escorted the paramedic from the G wing entrance to the cell, G2-18.
74. The paramedic recorded that he was with the man by 6.30pm. He confirmed that CPR had been ongoing for 15 minutes prior to his arrival. He also noted that the man's pupils were fixed and dilated, he had no heart rhythm throughout CPR, he had last been seen alive around 5.30pm, and his airway was obstructed by vomit. He attached a three-lead electrocardiogram which did not detect signs of heart rhythm. He confirmed death at 6.34pm.
75. Officer I was asked to keep a record of people entering and leaving G2 landing. Both nurses returned to work on the healthcare unit. SO A remained in charge of Residential Unit 3 until approximately 11.00pm. All of the other members of staff who had been involved were asked to go to the Brinsford's chapel. The chaplain and a member of the YOI's care team were available to provide immediate support.
76. According to the communications room log, the Governor (the then governing Governor) was contacted at 6.35pm and arrived at Brinsford at 7.13pm. The other members of staff remained in the chapel until around 9.30pm, when they were told they could go home. Officer E gave a statement to the police and left the YOI at around 11.30pm.

77. Police officers entered Brinsford and seized the man's custodial files. They also took an unfinished letter that he had written to his ex-girlfriend, and what appeared to be a suicide note. These documents were found in his cell.
78. The letter is addressed to the man's ex-girlfriend. In the space on the headed notepaper for indicating the wing or unit, he wrote "ITSU". This suggests that either he wrote this letter during his first night in custody, or did not indicate his location correctly. It reads as follows:
- "I don't really know what to say to you so I'll just say what comes into my mind first. I'm sorry that I could not be that man for you and if you want [want] this to be the end then I respect that even though [though] it hurts me to lose you and I know that I'm going not to be able to get over you."
79. The note is not specifically addressed to anyone, but refers to the man's ex-girlfriend in the third person. It reads:
- "She begged me not to do it but I feel that I have to do this. Please tell her that I love her."
80. The man has then written his ex-girlfriend's name and her mobile telephone number.
81. On 23 October, Nurse C scanned a copy of the discharge summary from hospital into System One, the medical computer system. The investigator spoke to the acting substance misuse team leader on 25 February 2010 about the procedure for scanning documents. She said that documents were not always scanned on the day of their arrival, and there was usually a pile of paperwork to be scanned into medical records. She said, however, that the documents would be looked at when they arrived.
82. In this case, there is no evidence to suggest that Nurse C was aware that the man had died the previous day, or that she alerted anyone to the potential significance of the hospital discharge summary. However, on the same day (23 October 2009), Nurse B, having been made aware of his death, looked through his medical records to familiarise herself with them. She saw the discharge summary and brought it to the attention of other members of staff.
83. On 26 October, the man's parents visited Brinsford and met with the Governor, the prison liaison officer, SO A and the safeguarding manager (responsible for suicide prevention at Brinsford). The next day, the man's ex-girlfriend visited the YOI with the team leader from the hostel where he had lived during his release, and his project worker at the hostel. They met the same members of staff who were present when the man's parents visited the previous day.

84. A critical incident debrief took place on 4 November. This was facilitated by the liaison officer and identified a number of areas for improvement. These are covered in the next section of the report.
85. The police interviewed two young offenders on 12 November. They were located in the cells adjacent to the man at the time of his death. Both of these young men thought he had originally been located in a shared cell on G wing, before being moved to the cell in which he died (G2-18) when he complained about his cellmate. The investigator asked the liaison officer to clarify whether this was the case. The liaison officer asked Officer E (the person who had received the man on to G wing and located him in a cell) about this issue, and he said that, to the best of his recollection, the man was located in G2-18 as soon as he arrived.
86. The forensic pathologist produced his final report on 25 November. The post-mortem examination took place on 27 October (though the paperwork is mistakenly dated 20 October), but the final report was also dependent on the toxicology report, which was produced on 17 November. The cause of death was hanging. The toxicology analysis found the presence of cannabinoids (cannabis), which suggested that the man had used the drug before his death, though it was not possible to determine whether the use was long-term or recent. Citalopram (an anti-depressant drug, usually dispensed under the brand name Cipramil) was also present at a level above the therapeutic range but significantly below the fatal level. He was not prescribed this drug by his GP, at the hospital, or whilst in Brinsford. It is not known how he acquired it or (because he had been in custody a very short time before his death) whether he took it in the community, in the police cells or whilst in the YOI.

## ISSUES

### Information sharing between agencies

87. The man was taken into police custody on the evening of 19 October 2009. He was subsequently admitted to hospital in the very early hours of 20 October, due to suspected use of illicit drugs. He was discharged back into police custody at approximately 9.30am. This was only hours before his court appearance and subsequent transfer to Brinsford. When he left the police station to be escorted to court, it was noted on his prisoner escort record that the hospital discharge papers were enclosed.
88. The man arrived at Magistrates' Court and was assessed by the CPN, who produced a written report. After sentencing, he was transferred to Brinsford and arrived at 8.05pm. SO B signed his escort form.
89. The procedure for young offenders arriving at Brinsford is detailed in the previous section of this report. During interview with the investigator on 10 February 2010, SO B discussed the escort record. Although he could not specifically recall the man's arrival at Brinsford, he said he would usually only sign the escort form if he was satisfied that it was accurate. He said that, if additional paperwork was supposed to be included but did not arrive, he would ask the escort staff to amend the form before he signed it. He believed that, because he had signed the form, it was likely that the discharge papers arrived with him.
90. SO B clearly understood during interview that when signing an escort record, he was acknowledging receipt of the young offender, their property, and any additional items such as paperwork, as stated on the form. However, the guidance notes for escort handover (which are attached to every escort record) are not completely clear, stating that:
  - “The Receiving Officer is signing for the following:
    - The correct prisoner/detainee is being received.
    - The property and cash described are complete and accurate at the time of the handover. Contractor staff will only sign for an intact bag against seal number.
    - The risks associated with the prisoner/detainee are understood.”
91. The guidance notes make no mention of additional documents, or of the need to check that this part of the escort record is accurate before signing. Prison Service Order (PSO) 1025 covers the use of the prisoner escort record and is similarly worded. Paragraph 4.6 indicates that the receiving officer signs to acknowledge “receipt of the prisoner, PER and property into his or her care”. It does not specifically mention additional documents that are recorded on the escort record as accompanying the prisoner.
92. Given that a whole section of the escort form is devoted to the possible inclusion of additional forms and documents, the guidance notes and PSO should be clear that the receiving officer is responsible for ensuring that it is

correct. The investigator contacted NOMS policy lead for the prisoner escort record, about this issue. He agreed to amend the documents to clarify that receiving officers are acknowledging receipt of additional documents.

**The guidance notes for prisoner escort records, and Prison Service Order 1025, should be updated to specify that the receiving officer is signing for receipt of any additional paperwork as indicated on the form.**

93. The situation is further complicated by the fact that hospital discharge papers are medical documents and therefore confidential. SO B explained that, when medical or security documents arrive with young offenders, they are passed to the relevant departments without being opened. He said that medical documents would be given to the person completing the initial health screening. In such cases, the person receiving the documents would not be required to sign the escort record or otherwise formally acknowledge receipt.

**Brinsford's reception processes should be updated so that an improved audit trail is created. Clinical or security staff members should sign to acknowledge receipt of documents.**

94. The healthcare assistant working in the reception area on 20 October 2009, made reference to a "discharge summary" in the computerised record of the initial health screening, but did not elaborate further. He did not record that the man had recently used illicit drugs to a degree that required hospitalisation. During interview with the investigator on 10 February 2010, he said he did not have access to any documentation and was not aware of anything arriving at Brinsford with the man. He also said, in response to some additional questions that the investigator asked on 24 February 2010, that he was not given any additional medical documents by any of the reception staff members.
95. The hospital discharge summary was scanned into the System One computer system on 23 October 2009, but may have arrived before this time. It is unlikely that anyone from the hospital would have sent the summary directly to Brinsford, as they would not be aware of the man's imprisonment. It also seems unlikely that the summary was sent from the hospital to his GP, and then on to Brinsford, in such a short space of time.
96. In my opinion, the most probable explanation is that the discharge summary arrived with the man on 20 October, and that the healthcare assistant did not record its content during the initial health screening process. There is no indication that recent and significant illicit drug use resulting in hospitalisation was considered, and no referral was made to the substance misuse team.

**Clinical decisions should be based on careful analysis of all information available at the time of assessment.**

97. The warrant that arrived with the man mentioned that he was "vulnerable and volatile and likely to be prone to self-harm". There is no evidence that this was considered as part of the reception process. Even if members of staff in

Brinsford's reception area thought that there was little risk of self-harm, it would have been good practice to acknowledge the alert on the warrant and explain why they disagreed with the assessment that had been made at court.

**Reception staff at Brinsford should be aware of additional information listed on warrants, and should consider it during the reception process.**

98. The CPN's report was faxed from the Magistrates' Court to Brinsford at around 12.30pm on 21 October. The investigator asked the liaison officer to identify the location of the fax machine, based on the number that the fax was sent to. He reported that the fax machine was based in Brinsford's reception area.
99. The investigator asked SO B about the procedure for dealing with faxes in the reception area. He said they are dealt with either by the reception officers or by administrative staff. The SO also said that the content of faxes was checked, regardless of whether the young offender was still in the reception area or had since moved to another unit (as was the case with the man). He said faxes would be sent to the required department depending on their content.
100. When the CPN report was faxed to Brinsford, a note was written on the fax cover sheet referring to the document as a "health assessment to go with warrants". The man's warrants would have been placed in his core record. Nevertheless, the report clearly states at the top that it is a mental health assessment, which would immediately suggest that it has medical significance.
101. A copy of the CPN report was found in the man's core custodial file, but not in his clinical record. Also there is no evidence to suggest that the content of the report was specifically brought to the attention of unit staff or medical staff.

**Reception staff should routinely check the content of documents received by fax, and take appropriate action, including informing other members of staff where necessary.**

**Bunk beds in cells**

102. Prisons cells are certified for either single or double occupancy. At Brinsford, some cells are certified for double use, but in practice are used only for single occupancy. Short of severe pressure on Brinsford's population, the cells would not accommodate two people.
103. In July 2009, another young man died in cell G2-18, the one where the man died, after using a ligature attached to the top bunk of the bunk beds. This cell was one of those that could accommodate two young offenders but was used in practice as a single cell. My colleague, who investigated the first death, raised the issue of bunk beds in single cells during his opening visit to Brinsford on 16 July. When he visited the YOI on 14 October he found that the situation had not changed. The following day, 15 October, he sent an

email to the Governor, repeating his concerns about the bunk beds. The Governor responded the same day, and said that removing the beds might “inhibit the flexibility we have at placing vulnerable prisoners in such cells for support in a buddying type arrangement”. He also pointed out that, even if the top bunks were removed, numerous ligature points would remain in standard cells.

104. After responding to my colleague, the Governor sent an email to a number of staff members at Brinsford, including the site manager. The message read:

“Please note my response to the investigator. I would welcome your views on my comments to him. I’m not sure he will agree and as such could you ... identify how many cells we would need to convert to single beds and let the site manager know. It should only be those designated as single cell occupancy. Site manager could you give me a rough estimate of the work and costs should we have to do it + the time and costs of converting one back should we need to do this.”

105. The following morning 16 October, the site manager replied to the Governor, saying that each cell requiring conversion would require two members of staff, and would take four hours. Four days later, on 20 October, the Governor forwarded the email to my colleague for his consideration.

106. My colleague was away from the office and so his response was delayed until 26 October. By this time, the man had died, also in cell G2-18, and also by using the top bunk as a ligature point. My colleague noted the Governor’s comments about the time and cost involved, but pointed out that there had now been two apparently self-inflicted deaths with the same ligature point used. He also emphasised that the presence of other ligature points in a cell was not a reason to retain one that could be removed.

107. The Governor responded to my colleague on 27 October. He wrote that

“We have been converting the bunk beds in single occupancy cells for many months (approx nine months) on a rolling programme and will continue to do so until all are converted”.

He also anticipated that the programme would have all the single occupancy cells converted within four weeks.

108. The email that the Governor sent to his staff on 15 October did not suggest that a programme of conversion was already underway. He made no mention of continuing with an existing programme, but asked for the number of cells that would need to be converted, and the time and cost involved “should we have to do it”.

109. The investigator spoke to the site manager on 24 February 2010. He said that the work to remove the bunk beds from single cells started shortly after the exchange of emails in October 2009, and that this was a new programme

rather than the continuation of an existing arrangement. He estimated that bunk beds were replaced with single beds in approximately 100 cells.

110. The removal of bunk beds from single cells is a positive step in that it reduces the number of possible ligature points. The evidence I have seen suggests, however, that this action was taken only after a second young man died by way of a ligature attached to the same bunk bed.

### **Access to medical equipment**

111. When the man was found, it quickly became apparent that a mouth guard would be required for CPR to be performed properly. This piece of equipment was not immediately available because neither of the members of staff present were carrying it. However, a mouth guard was found within seconds and given to the officer who was starting CPR. A number of these items were kept in emergency boxes on the unit, but in this case one of the officers on the landing had one with him.
112. It is not mandatory for prison officers to carry mouth guards. In interview both SO A and Officer F said they felt that they should be part of the standard equipment to be carried by all officers. Whilst the delay in this case was minimal and almost certainly did not make a difference to the outcome, immediate access to resuscitation aids such as mouth guards could be essential in other circumstances.
113. When delivering feedback to the deputy governor on 22 January 2010, the investigator recommended that, in addition to placement in the emergency boxes, mouth guards should be available to all those members of staff who wished to carry them. I am pleased to learn that the deputy governor was already in the process of acquiring a number of pieces of equipment, including mouth guards, to create an emergency kit for officers to carry on their belts.
114. The liaison officer confirmed to the investigator on 4 March that emergency pouches containing mouth guards and gloves had arrived at Brinsford and been distributed to officers to carry on their utility belts.
115. The emergency bag and defibrillator were taken to the man's cell from the healthcare unit. My colleague, who investigated the death at Brinsford in July 2009, commented on a delay with the medical equipment arriving on the unit. There was no such delay in this case. The RGN explained during interview that, following the death in July, she had rearranged the items and ensured that only essential equipment was included. By doing so, she had managed to combine the two emergency bags into a single bag, thereby making it easier to carry.
116. The investigator visited Brinsford's healthcare unit, and found that the emergency bag was still heavy and somewhat unwieldy. This is not a criticism of the RGN's attempt to improve the process. Emergency bags are heavy because they contain items such as oxygen cylinders. The combination of carrying a heavy emergency bag and a defibrillator, plus the

obstacle of locked doors and gates, can cause delays in medical equipment reaching the unit where it is required.

117. The RGN informed the investigator of a regional project to standardise emergency bags and place them on residential units in addition to the healthcare department. He contacted the healthcare manager for HMP Swinfen Hall and the project's leader, to enquire about progress. She said the plan was for identical bags (both in terms of the items included and their location within the bag) to be placed on residential units in Brinsford and in the other prisons in the region. The idea behind this is that medical staff members will have increased ease of use and confidence if they are transferred to another establishment within the region. Her aim was for the emergency bags to be available on residential units by the end of March 2010. This is a welcome development.
118. The liaison officer told the investigator on 4 March that Brinsford had taken delivery of additional defibrillators, bringing the total number on site to six. The intention is for a defibrillator to be available on each residential unit. At the time of writing, members of unit staff were awaiting training in the use of defibrillators.

**Staff training in the use of defibrillators should take place without delay.**

**The additional defibrillators should be located on residential units without delay.**

119. The critical incident debrief held at Brinsford on 4 November 2009 found that the emergency boxes on the residential units were not checked regularly. Nobody was identified as being responsible for checking the contents of the boxes or ensuring that they were fit for purpose. This did not impede staff when responding to the man, but has potential implications for the response to future medical emergencies.
120. A further meeting at Brinsford on 5 January 2010 confirmed that equipment in the emergency boxes had been replenished, and that a notice to staff would be issued identifying the members of staff responsible for checking them.

### **Clinical issues**

121. The clinical reviewer conducted a review of the man's medical care. The full review is included as an annex, and the main findings and recommendations are summarised below.
122. She found that there was nothing in his behaviour to alert members of staff that he was considering harming himself. She noted that the report written by the CPN at court did not appear to have been made available to healthcare staff. In terms of the hospital discharge records, she found that although there was a brief mention of discharge paperwork in the initial health screening, there was not sufficient clarity about what this meant. Although there was no evidence that the discharge paperwork was considered as part

of the screening, she concluded that it would not necessarily have led to the healthcare team taking a different course of clinical care.

123. In conclusion, the clinical reviewer made the following recommendations, which I endorse:

**The clinical review panel recommends that healthcare staff should clearly record the details of additional information that was available at the time of the initial health screening.**

**Entries in computerised clinical records must be attributable to the member of staff concerned in the same way that a written record must be dated and signed by the person making the entry.**

### **Alcohol and drug services**

124. The man's parents asked about Brinsford's procedures for people who arrive under the influence of alcohol or drugs, and the services that are available for drug and alcohol withdrawal and detoxification.
125. The investigator spoke to Brinsford's acting substance misuse team leader, on 25 February. She explained that, when prisoners admit to illicit drug use or there is information to suggest that this is the case, a referral is made during the initial health screening process to the substance misuse team. Young offenders who have been referred are seen the following day by a doctor and a substance misuse worker, at which point they are assessed and drug tested. Clinical plans are then developed for how to address the needs of the person. In addition, the Counselling, Assessment, Referral and Throughcare (CARAT) team see young men on the ITSU and offer ongoing psycho-social support.
126. Alcohol services are also available. A similar referral and assessment process would be made, with a detoxification programme available.
127. There is limited support for young offenders arriving at Brinsford during the evening under the influence of drugs or alcohol. A number of medicines can be prescribed on the first night as an interim measure, but further clinical care would need to be authorised by a doctor on the following day.
128. In the man's case, a referral was not made to the substance misuse team. There is no evidence to suggest that anyone in the reception area or on the ITSU thought he was under the influence of drugs or alcohol. As has already been discussed, the hospital discharge summary was either not available or not considered as part of the reception process.

## **Attention deficit hyperactivity disorder (ADHD)**

129. The man's birth mother asked whether staff at Brinsford were aware of his ADHD, and if so, whether he was subject to 'suicide watch' as a result.
130. He was diagnosed with ADHD earlier in his life and, although he had previously been prescribed Ritalin, he had not taken this medication to control his condition since the age of 16. The clinical reviewer obtained his GP records, which show that he was prescribed Methylphenidate (a medication for the treatment of ADHD) in August 2009. No further prescriptions were issued after this time. The condition is not mentioned in his initial health screening or his secondary health screening. This suggests either that he did not mention it during the screenings, or that neither practitioner made a record of it.
131. Even if members of staff were aware of the man's ADHD, it would not automatically mean that he would be considered a risk of suicide or self-harm, and monitored as such. This type of monitoring is based on observations or information that suggest an increased risk. The members of staff who came into contact with him between 20 and 22 October 2009 did not consider him at risk of suicide or self-harm, and so an increased level of monitoring was not introduced.
132. As part of the clinical review, the clinical reviewer drew attention to the completion of both the initial and secondary health screening within 24 hours of the man's arrival at Brinsford. She noted the quick response of the ambulance on 22 October, and commended the prison staff who ensured that the paramedic was able to gain access to him without delay.

## **Provision of care for members of staff**

133. After the man's death, the members of staff who were directly involved were asked to go to the chapel. The chaplain and a member of the care team were available to provide immediate support. During interviews with the investigator, members of staff were complimentary about the care team and felt positive about the support that they had been offered. However, they also commented that information from senior management was not forthcoming, and that they were effectively isolated in the chapel.
134. Paragraph 5.3 of Prison Service Order (PSO) 2710 refers to debriefing that should take place following a death in custody. It states:

“After a death in custody many staff experience “normal” short-term stress reactions (distress and tearfulness, shock, feelings of guilt) and need to be reassured that these reactions are normal. Debriefings are generally found useful after a death in custody if they provide an opportunity to share experiences, dispel inappropriate feelings of guilt and self-blame and provide reassurance that stress is normal in these circumstances. *There must always be a hot debrief immediately after the incident and provision for this should be made in local contingency*

*plans. A senior member of staff must act as debriefer and a duty care team member must also attend. The purpose is not to analyse or re-live the incident. Nor is it an opportunity to apportion blame or pre-judge investigation findings. The hot debrief should focus on reassurance, information sharing, normalisation and how staff can support each other. Particular reassurance is needed when the prisoner died after unsuccessful resuscitation attempts, when staff involved are more likely to feel a sense of failure.”*

135. Brinsford’s contingency plan for actions following a death in custody does state the need for an immediate hot debrief. However, during interview with the investigator, staff members were unclear about whether such a debrief had taken place. The deputy Governor confirmed to the investigator that, whilst he and the Governor intended to hold a hot debrief, it did not actually happen. Members of staff remained in the chapel for several hours, and eventually went home without a debrief taking place.
136. The critical incident debrief, which took place on 4 November 2009, identified staff care as an issue. Members of staff reported feeling isolated, and said that they were not kept informed about what they should have been doing, and whether they were needed. They felt that someone should have been identified as a post-incident manager to address the needs of those involved.
137. The investigator spoke to the deputy Governor about improving the process. The Governor said that, for any future serious incidents, members of staff would be brought together in Brinsford’s administration area. They would then be in closer proximity to managers, who would facilitate improved communication. A hot debrief would also be conducted, with a written record of attendees and subjects discussed.

**Following a death in custody, a hot debrief should take place as soon as possible, and before members of staff involved leave the establishment.**

### **Emergency response**

138. After the man was found by Officer E, Officers F and H arrived at his cell quickly and began performing CPR. Both officers had received instruction in CPR around two years previously, during their initial prison officer training course. In addition, both officers had undertaken CPR training in previous occupations. As a result, they felt confident in attempting resuscitation. Officer F had recent experience of attempting CPR, having been involved in the previous death at Brinsford in July 2009.
139. Neither Officer F nor Officer H could be certain about whether they had received refresher training in CPR. SO A told the investigator that, whilst refresher training used to take place annually, this no longer seemed to be the case. It appeared to be simply coincidence that the members of staff involved were relatively new in post and had, therefore received CPR training.

140. The issue of CPR training was identified at Brinsford's critical incident debrief. The investigator met with the training manager on 22 January 2010 to discuss a programme of refresher training. He told the investigator that first aid training would be provided for all senior officers, and that at least ten officers per unit would receive CPR training. He hoped to commence the programme by February 2010.
141. The investigator spoke to the training manager by telephone on 25 February to check on the progress of CPR and first aid training. Although the proposed February start date had been delayed, he had booked nine 'Heartstart' (training covering CPR) sessions for the week commencing 14 March. Each session can accommodate up to 12 members of staff, meaning a potential 108 people with updated training by the end of that week.

**The 'Heartstart' training should go ahead as planned, and be followed up with a rolling programme of refresher training.**

142. The first aid training for senior officers had also been delayed, and there was no proposed start date. The training manager explained that such training involved some logistical problems as it would mean senior officers being away for two days. Nevertheless, he hoped to facilitate the training.

**I recommend that senior officers should receive first aid training.**

143. During interview with the investigator, Officer F said members of staff were aware that they needed to respond immediately to emergency situations, but were unclear about what to do when they arrived. He said there were lots of people around the man's cell who were not directly involved and were unclear about how they could help. The officer acknowledged that it was difficult to train staff for such serious events, but felt the situation could be improved.
144. The same issue was raised during Brinsford's critical incident debrief. The investigator spoke to the training manager about the issues around responding to medical emergencies. Whilst members of staff were aware of the need to respond immediately, they were not always sure how they could be of assistance after they arrived. This led to many people being present but offering no real benefit. The manager thought the situation could be improved by reiterating to senior officers the need for them to co-ordinate the emergency response, directing members of staff where necessary and advising others to leave the area.
145. Issues around emergency equipment, care for members of staff, and training were raised during the critical incident debrief and have been covered above.
146. The critical incident debrief also covered issues of communication regarding emergency procedures. The need for the communication officer to ascertain the nature of a medical emergency ('code blue' or 'code red') before alerting members of healthcare staff was emphasised. A meeting at Brinsford on 5 January 2010 clarified that a new protocol would be developed, and a

governor's order issued, about the most appropriate radio message to be used in emergency situations.

147. The debrief identified that not all prison officers were carrying anti-ligature knives, and that some staff members had encountered problems in trying to obtain one. By 5 January, additional anti-ligature knives had been ordered and distributed as required.
148. When the man was found by Officer E, the response was swift. Officers from the unit quickly cut him down and commenced CPR, continuing until staff from the healthcare unit arrived. The two nurses from the healthcare team continued with CPR until the paramedic arrived. It seems that all of the people involved made valiant and sustained efforts to resuscitate him, but sadly they were unable to do so.

### **Single cell accommodation**

149. The man's parents asked why he was allowed a single cell if staff at Brinsford were aware of his risk of self-harm and suicide. As mentioned throughout the report, members of staff at Brinsford did not identify any cause for concern during his time there. Even very shortly before his death, he appeared well, and gave no indication that he was at increased risk of suicide or self-harm.
150. The issue of communication, in terms of the hospital discharge notes and the CPN report, is covered elsewhere in this report. There is no indication that these documents were considered prior to the man's death. As a result, he was not considered a risk to himself.
151. In summary, the man was not thought to be a high risk of self-harm and suicide, and so his cell sharing assessment was not considered in those terms. He would not necessarily have been prevented from sharing a cell if he was thought to be at risk, though this would probably have been considered as part of his cell sharing assessment.
152. The previous death at Brinsford occurred on 7 July 2009, in cell G2-18 on Residential Unit 3. The man was serving a sentence at Brinsford during this time. Although he had spent some time on G wing, he had been located on B wing – part of Residential Unit 2 – since late June. I am unable to be certain whether or not he knew about the previous death and where it took place. There does not appear to be any record of him mentioning it to anyone.

## CONCLUSION

153. The man had served a number of previous custodial sentences when he was sentenced to 16 weeks' imprisonment in June 2009. Although brief comments were made on various documents about previous self-harm, he did not appear to be at increased risk between June and August, when he was released.
154. When he was returned to custody on 20 October, his warrant indicated that he posed an increased risk of suicide. It is also likely that discharge documents relating to his hospital admission earlier on the same day, were available to the person completing the initial health screening. However, they do not appear to have been considered during the health screening process. Similarly, a mental health assessment indicating an increased risk of suicide was faxed to Brinsford on 21 October, but the content does not seem to have been noted or made available to healthcare staff.
155. Over 20, 21 and 22 October, the man did not present to members of staff in a way that gave rise to concerns about him. Around 5.00pm on 22 October, he was seen by members of staff and seemed well. I am satisfied that there were no signs that he was contemplating harming himself, or that the staff could have prevented his death. Just after 6.00pm, he was found hanging in his cell. Despite valiant efforts, resuscitation was unsuccessful.
156. My recommendations relate primarily to communication, information sharing, and consideration of the content of documents. Whilst it would not necessarily have changed the outcome, some joined-up working might have alerted members of staff to his potential risk of suicide.

## RECOMMENDATIONS

1. The guidance notes for prisoner escort records, and Prison Service Order 1025, should be updated to specify that the receiving officer is signing for receipt of any additional paperwork as indicated on the form.

*The recommendation was accepted by NOMS. An amendment will be made to the PER guidance notes to make it clear that the receiving prison is signing for receipt of the prisoner and any accompanying paperwork. The change will be rolled out through natural stock rotation and use.*

2. Brinsford's reception processes should be updated so that an improved audit trail is created. Clinical or security staff members should sign to acknowledge receipt of documents.

*The recommendation was accepted. Brinsford reported that the management of the reception area had been re-structured.*

3. Clinical decisions should be based on careful analysis of all information available at the time of assessment.

*The recommendation was accepted. Brinsford reported that it was standard practice to make clinical decisions based on careful analysis of available information.*

4. Reception staff at Brinsford should be aware of additional information listed on warrants, and should consider it during the reception process.

*The recommendation was accepted and will be taken into consideration as part of a review of Brinsford's reception process.*

5. Reception staff should routinely check the content of documents received by fax, and take appropriate action, including informing other members of staff where necessary.

*The recommendation was accepted and, like the above recommendation, will be taken into consideration as part of a review of Brinsford's reception process.*

6. Staff training in the use of defibrillators should take place without delay.

*The recommendation was accepted. Brinsford reported that defibrillators had been ordered, locations had been identified, and they were awaiting distribution.*

7. The additional defibrillators should be located on residential units without delay.

*The recommendation was accepted. As with the above recommendation, Brinsford reported that defibrillators had been ordered, locations had been identified, and they were awaiting distribution.*

8. Following a death in custody, a hot debrief should take place as soon as possible, and before members of staff involved leave the establishment.

*The recommendation was accepted and had been incorporated into the contingency plan for the follow-up to deaths in custody.*

9. The 'Heartstart' training should go ahead as planned, and be followed up with a rolling programme of refresher training.

*The recommendation was partially accepted. Heartstart training is no longer supported by NOMS as it does not meet the requirements set out by the Health and Safety Executive (HSE). At the time of writing, Brinsford's governing Governor was in the process of identifying an alternative programme that meets the HSE requirements.*

10. I recommend that senior officers should receive first aid training.

*The recommendation was accepted. A training programme was being put into action to train more senior officers in first aid.*

### **Clinical recommendations made by the clinical reviewer**

1. The clinical review panel recommends that healthcare staff should clearly record the details of additional information that was available at the time of the initial health screening.

*The recommendation was accepted. Brinsford reported that additional information about patients is denoted by individualised markers on the medical computer system.*

2. Entries in computerised clinical records must be attributable to the member of staff concerned in the same way that a written record must be dated and signed by the person making the entry.

*The recommendation was accepted. Brinsford reported that records can be attributed to individual members of staff through unique staff login details.*