Investigation into the circumstances surrounding the death of a man at HMP Brixton in April 2005

Prisons and Probation Ombudsman for England and Wales
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This is the report of an investigation into the death of a man who was found hanging and died in HMP Brixton in April 2005, aged just 24 years. He had arrived in the prison the previous evening, having been convicted but not sentenced at a Magistrates' Court. He was at Brixton for less than 24 hours before he died.

My Assistant Ombudsman and an investigator undertook the investigation, a key part of which was to make sure that the man's family had an opportunity to raise any concerns about his death. My colleagues were able to meet with the family, and I very much appreciate their willingness to discuss the man's death so soon after their bereavement. The loss of a loved one is always distressing, but especially so in these tragic circumstances. I offer the family both my thanks for being involved in the investigation, and my sincere condolences for their loss.

I would also like to thank the Governor of Brixton, and his staff, for their assistance in the investigation. The South Lambeth Primary Care Trust also undertook a review of the man's medical care. I am grateful to the reviewer for his excellent review and his careful consideration of the issues.

My report includes a number of recommendations. Some more minor issues also arose from this investigation, but I am conscious that the currency of formal recommendations should not be devalued through overuse. I have therefore included other points for action in the text of the chapter entitled Conclusions.

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PRISONS AND PROBATION OMBUDSMAN **October 2005**

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Summary

The man who is the subject of this report was 24 years old when he died in April 2005. He had been in HMP Brixton for less than 24 hours.

On Saturday 16 April, the man was stopped by security staff in a supermarket on the grounds that he had been seen stealing items worth about £12. He said he was carrying a knife and handed it to staff, who called the police. He was arrested and charged with possessing an offensive weapon in public.

During his interview with police, the man made some remarks that gave the police cause for concern about his mental health. They recommended that, after he appeared in court, he should be seen for a psychiatric evaluation. He was also seen by a police doctor, who noted that he showed increasing signs of paranoia.

The man who died was held in police custody over the weekend, and appeared in court on 18 April. He was found guilty, and the hearing was adjourned for a pre sentence report. He was remanded to Brixton. The copies of the police doctor's assessment, but no other information relating to the police concerns about the man's mental health, were passed to the prison.

The man went through Brixton's reception process that evening. He was seen by a nurse, and told her that he had self harmed some years ago. The nurse did not make a note of the details. Procedures required that he be referred for a mental health assessment. There are differing accounts as to what happened, and there are no notes to say what was done, or the outcome of any assessment. It is not clear whether the police doctor's medical assessment was taken into account in any decisions that were made. Clinical staff say that he did not look depressed and said he was fine. He was talking freely and making good eye contact.

Healthcare staff decided not to place him on an open F2052SH (a suicide warning form) because he had not made a recent self harm attempt and said that he did not currently feel suicidal.

The man does not appear to have given any of the prison staff who saw him that evening, or those he saw the following morning when he attended the induction programme, any reason to be concerned about his well being. The same is true of his cellmate.

When his cell was unlocked after lunch on 19 April at about 1.55pm, to take him back to the induction course, he was discovered to be hanging. Staff called for help, and did their best to resuscitate him, but it was not possible to save him.

The man had not given details of his next of kin to the prison, and so they had to ask the police to help. The police broke the news to his sister in the early hours of 20 April.

During the course of the investigation, a doctor on behalf of South Lambeth Primary Care Trust, conducted a clinical review of the medical care that the man received while in prison. The review identifies several shortcomings, and makes a number of recommendations.

I, too, have a number of concerns about the way he was dealt with during his short time in custody, and my report makes a number of recommendations. However, I have commended staff in their efforts to resuscitate him. I am also impressed by the support provided to staff and prisoners after the man's death.

The investigation

My Assistant Ombudsman and an investigator carried out the investigation into the man's death. Notices were issued to staff and prisoners telling them of the investigation and its terms of reference, and offering them the opportunity to participate. Two prisoners came forward and provided information to the investigation team.

My investigators visited Brixton and saw those parts of the prison where the man would have been, including the reception area, the induction unit and the cell where he died. They met the Deputy Governor, representatives of the Prison Officers' Association, and the Chair of the Independent Monitoring Board. They reviewed all the relevant documentation, and interviewed a number of staff and prisoners.

A doctor, on behalf of South Lambeth Primary Care Trust, undertook a clinical review of the medical care the man received. The Assistant Ombudsman met with the doctor, and shared with him information obtained during the course of the investigation. Unfortunately, it was not practically possible for interviews with medical staff to be conducted jointly with the doctor, and so my investigators provided him with transcripts of their own interviews. The doctor then conducted two separate interviews to enquire further into some of the clinical issues.

My investigators also met with the police to discuss both the nature and scope of my investigation and that of the police, who are acting on behalf of the Coroner. The police said that they did not consider there were any suspicious circumstances surrounding the man's death. My investigators have also been in touch with the Coroner directly. Upon completion, my report will be sent to the Coroner to assist him in his enquiries into the man's death.

One of my Family Liaison Officers and the investigator met the man's family during the course of the investigation. The family had a number of concerns about the support he received while in prison custody. They also raised questions about the way they were notified of his death, and why they were not warned how quickly the media would be told of his death.

Brixton prison

Brixton is a local prison, serving the Inner London and Southwark Crown Courts. It holds remand and convicted prisoners. There are four main residential units and a healthcare centre.

The last four apparently self inflicted deaths in Brixton were in December 2003, January 2004, March 2004 and September 2004. Only the death in March 2004 raised an issue of specific relevance to the circumstances of the man's death, in that a problem with access to Listeners was identified. The investigation into his death has raised concerns that Listeners may not always be available on reception and induction.

The prison has a suicide and self harm prevention policy, and a document of local operating practice. There is a Suicide Prevention Co-ordinator, whose task is to provide support and guidance to the prison in line with local and national guidelines. Safer Custody committee meetings are held monthly.

The document setting out the suicide and self harm operating practice says that reception staff, first night custody officers and healthcare staff should, on reception, assess those considered as being at risk using standard screening procedures and information from the Prisoner Escort Record (the PER form).

Her Majesty's Chief Inspector of Prisons carried out an inspection of Brixton in February 2004. The inspectors had some concerns about reception procedures, but described improvements in first night and induction arrangements. They said that healthcare staff were able to assess new prisoners and give basic information on the availability of healthcare services. However, the inspectors' report said that the healthcare staff who worked on reception were under considerable pressure.

My investigators also observed the reception process early one evening, and discussed the process informally with staff. There was a view expressed that the focus at reception was on getting prisoners through the process, rather than on the prisoners themselves. Brixton recognises that the reception arrangements could be improved, and is in the process of drawing up plans to achieve this.

Brixton's operational plans for dealing with a death of a prisoner were last updated in October 2003. They say that when dealing with an attempted suicide, serious injury or apparent death of a prisoner, the communications room is to contact 'Hotel 6' (the healthcare officer carrying the emergency radio) to say that urgent medical assistance is required, and then call an ambulance. The Communications Officer must not wait for further details before calling an ambulance.

Brixton also has healthcare protocols for medical response codes. These say that, in a code 1 emergency, Hotel 6 should attend, assess the patient, and decide whether an ambulance is required. A Code 1 emergency is defined as life threatening, including where a prisoner is hanging and not responsive.

Events leading up to and after the man's death

His time in police custody

Early on 16 April 2005, the man is alleged to have been seen in a supermarket stealing items worth £11.99. He was stopped by supermarket security staff. While detained in the store, he said that he was carrying a knife, which he handed to the security staff. The knife was a six inch bladed carving knife. The security staff called the police.

When the police arrived, supermarket staff said they did not want to prosecute him for shoplifting, as the total amount he had stolen was too low. Police questioned the man about the knife. He said that he had had it for a while, and that he carried it for protection as he was homeless. He was arrested and taken to the police station where, at about 9am, a risk assessment form was completed. As part of the assessment, he was asked if he had a mental health condition, and if he had ever tried to harm himself. He replied "no" to both questions. The police custody officer concluded that, at that time, the man presented no known risk.

Later that afternoon, the man was formally interviewed by the police. At about 3pm, he was charged with possessing an offensive weapon in a public place.

During the police interview, the man appeared very uneasy and nervous. He freely admitted carrying the weapon, and said he regularly stole from the supermarket to feed himself, and to allow him to buy a small amount of cannabis. He said that he wanted to go to prison for 12 months, as he thought it was the best thing for him. He asked if there was an organisation that could help him, which the police officer understood to mean help relating to his mental health. The man spoke of being homeless, and said that it was difficult for him to control his anger when members of the public looked at him. He was worried that one day he might hurt someone if they continued to look at him, and said that more than once he had chased people on a push bike with a knife. He knew this was wrong, but he could not control how he felt.

The police officer conducting the interview thought that he might have mental health problems. He recommended that, after the man appeared in court, he should be seen for a psychiatric evaluation. He wrote a note about the case, and the interview, on a police case summary form.

Once the man had been charged, the police decided against giving him bail, on the grounds that he was homeless and that if he was released he would fail to attend court. He was therefore to be detained until 18 April.

After the interview, the police arranged for a doctor's examination. Not all prisoners are seen by a doctor. In this particular case, it was arranged because of the concerns identified during the interview. At 4pm, the doctor conducted a ten minute examination and completed a Forensic Medical Examination form. The doctor said that the man was fit to be detained and transferred, and noted:

“Prisoner admits to smoking cannabis and shows increasing signs of paranoia. Denies any medical or psychotic illnesses. Requested sleeping tablet.”

After the medical examination, the man was returned to a police cell. Throughout the time that he was in police custody, he was checked every hour.

At about midday on 17 April, the doctor visited the man in his cell, and completed a second Forensic Medical Examination form. The doctor said that he was still fit to be detained and transferred, and noted:

“Prisoner seen yesterday. Requesting sleeping tablet.”

The police told my investigators that, as he was showing signs of paranoia, the medical examinations should possibly have come to some conclusion in relation to his mental health. They said that they are conducting their own investigation into the way the man was assessed while in police custody, and would be reporting the outcome to the Coroner.

On 18 April, the man was transferred to a Magistrates’ Court. He arrived at 10am. The Prisoner Escort Record that accompanied him said that he was a risk because he concealed weapons and had drug/alcohol problems. He was not considered to be at risk of suicide or self harm.

He was held in a cell at court, where he was checked several times an hour. At 3.26pm, he appeared in front of the magistrates. He was found guilty of having an offensive weapon in a public place. The police made no recommendations to the court with regard to bail. The hearing was adjourned to 26 April for a pre sentence report. The magistrates decided that, meanwhile, he should be remanded in custody. By 3.39pm, he was in a van en route to Brixton prison.

The man’s prison records contain the following documents from the police:

- the two Forensic Medical Examination forms
- the police risk assessment, conducted when he first came into police custody.

The copies of the Forensic Medical Examination forms passed to the prison are quite poor photocopies and difficult to read. The police did not pass on any other information relating to their concerns about his mental health, or any details of their interview with him.

Reception at Brixton

We do not know exactly what time the man arrived in Brixton. He would have been taken off the van, had his property and court warrants checked, and offered a meal. On his personal summary sheet, completed before he arrived at the prison, his address, next of kin and details of anyone to be notified in an emergency are all given as "NFA" (no fixed abode).

An officer interviewed the man as part of the reception process. The officer thought the interview would have taken place between 6pm to 7pm, and that the man might have been in the prison about an hour before that. One of the documents he completed was a cell sharing risk assessment. On the basis of what the man told him, together with the Prisoner Escort Record, court warrant and any other available paperwork, the officer assessed the man as a low risk of harm to others.

The officer told my investigators that he explained to the man that he could be put on the prison's induction programme the next day, and he readily agreed. He would also have given him an induction pack, and the officer would have answered any queries he might have had. He said the man showed no signs of being distressed.

The man then would have been strip searched, and kept in a holding cell until he could be seen by medical staff.

There is normally a Listener on reception (a Listener is a prisoner trained by the Samaritans to provide a listening ear to prisoners who are distressed). One of the Listeners in the prison told my investigator that he recalled that there was a problem on 18 April and no Listener was taken to reception. He thought there was a similar problem on the induction programme the following day.

Medical assessment

A member of the Healthcare staff interviewed the man that evening - a nurse with a doctor in the room, sitting at an adjacent desk. The nurse completed the medical assessment section of the cell sharing risk assessment form. She assessed the man as a medium risk, that is, not an immediate risk but needing regular review. She also indicated on the form that there were no self harm concerns.

The nurse also went through the first reception health screen form with the man. He said that he did not have any concerns about his health. He gave no details about his next of kin.

Questions 10 to 13 on the first reception health screen form are about the prisoner's mental health. Question 10 asks about any previous psychiatric treatment. He said he had not received any psychiatric treatment. Question 11 asks if the prisoner has ever received any medication for mental health problems, to which he also answered 'no'.

Question 12 asks if the prisoner has ever tried to harm himself. He said that he had, outside prison. The form has a space for giving 'Detail of the most serious and most recent' incident. This section of his form is blank. The nurse told my investigators that she asked him when he had self harmed, and he said some years ago. Although she did not remember exactly, she thought it was more than six years ago. She said that she did not put this information on the form because she thought it was too long ago to be treated as the most recent incident. She said she had been told that the most recent incident meant about two years ago. Unless she had concerns about a prisoner's current state, she would only put down details of any incidents that occurred in the previous two years. In this particular case, she had asked him if he had any current feelings or intention of harming himself, and he said no, he was absolutely fine. He was talking freely and had good eye contact, so she did not think it was necessary to put any further information on the form.

The first reception health screen form says after question 12:

> "If 'yes' recorded to questions 10,11 or 12 (outside of prison) refer for mental health assessment."

Despite the man's answer to question 12, that he had indeed tried to harm himself outside prison, no formal referral for a mental health assessment was made. My investigators asked the nurse why she had not done so. She said that the doctor was listening to her interview and was happy not to take any further action.

The doctor told my investigators that she would have been listening in on the interview, unless she had been called out of the room, to see if the prisoner was obviously depressed. She remembered asking the man, at the end of the interview with the nurse, whether he wanted any medication for the night. She said she recalled that he did not look depressed. She did not recall that he had said he had tried to harm himself in the past. Her understanding was that the mental health assessment could be done by the nurse, if she had had the appropriate training. She said the assessment would have been her own responsibility if the case has been referred to her, but it was not.

My investigators asked the nurse what account she had taken of the police Forensic Medical Examination forms. She said that she did not recall seeing them. She agreed that the forms were difficult to read, but said she would have made an effort to decipher them if she had seen them. She said that the reference to paranoia might have concerned her, and she would have correlated this information with what the man was saying and how he was presenting. The doctor said the Forensic Medical Examination forms were usually available to medical staff at the time of the assessment, but sometimes they came late, and the nurse would then have to take account of them later. There is no indication in his medical records as to what information was considered by nurse during the course of her interview with him.

Question 13 on the first reception health screen form asks if the prisoner might consider harming themselves in prison. He answered 'no' to this question. The form has a section for the interviewer to record their impression of the prisoner's behaviour and mental state. In this case, the nurse ticked 'nil of note'.

The form says after question 13:

> "If 'yes' recorded to questions 12 or 13, consider opening a F2052SH."

(An F2052SH is a form used by prisons to monitor a prisoner who may be at risk of suicide or self harm.)

The nurse said she would have opened an F2052SH if the self harm attempt had been recent, and if the man currently felt like self harming.

The nurse also opened an Inmate Medical Record (IMR) for the man that evening. The entry for 18 April reads:

> "Seen in reception – states fit and well. Declined to see MO."

The entry is signed by the nurse, but not by the man who is the subject of this report.

The nurse told my investigators that she had worked in the prison since October 2004, and for two months of that time she had been on holiday. She said she only occasionally worked on reception. She said she had been trained in how to complete the first reception health screen form.

The Healthcare Centre has guidance on the process to be followed on reception. It is dated July 2002. It explains how a Healthcare Screening Assessment (form 2169) should be completed. This is a different form to the current first reception health screen form being used in Brixton.

The guidance says that, if the screen is entirely negative, the prisoner should be offered the opportunity to see the medical officer. If he declines, the healthcare officer must record this in the IMR and obtain a signature to that effect from the prisoner.

Location on G wing

While in reception, the man became friendly with another prisoner and suggested that they share a cell together. When the reception process was finished, the prisoners were taken to G wing, which holds new prisoners and those returning from court. A Senior Officer was on the wing. She checked to see if any prisoners wanted to share with each other, and the man who died and his new friend said that they did. The Senior Officer put them in cell G2.24 in the 'first night' area, although the man's new cell mate was not new to Brixton.

The cell mate says that the man who died talked to him of problems with his family, with whom he said he did not have contact, about drugs, about being homeless, and his worries about being in prison. He says the man seemed unhappy, but not abnormally so, and he would not have thought he was suicidal. The cell mate gave the man who died his telephone number, and suggested that he ring him when he was released from prison. The cell mate says he wanted to help him find a home and a job. That evening they watched the television in their cell, and ate the breakfast packs they had been given for the next morning. When the cell mate went to sleep, the man who died was still awake and reading a magazine.

The next morning, the cell mate was unlocked at about 7am for a court attendance. He says he reminded the man who died to give him a call when he was released.

Induction course on the morning of 19 April

At about 7.45am, and officer came and unlocked the man and took him to a holding room while other prisoners were being collected. He says the man came very willingly. There was an officer at the holding room, and he recalls that the man who died still showed no signs of distress.

The prisoners were taken to the induction unit, where the officer who escorted him and the officer in the holding room were scheduled to run the day. During the morning, the prisoners were given talks by the chaplaincy and the chair of the Independent Monitoring Board. They were also shown a video about the role of Listeners in the prison. There was a prisoner on the induction programme who proved disruptive, and was annoying other prisoners, and so was eventually removed from the course. Neither of the officers running the course remembered the man who died being particularly upset by this incident.

At about 11.10am, the induction prisoners were taken to the library. It seems that the man who died did not take anything out of the library. They were then returned to G wing between about 11.30am and 11.45am. The Senior Officer says that they would not have been locked in their cells, but would have been able to mill about on the landings until called to get their lunch. Lunch is served from about 11.30am to 12.15pm. Once the man had got his lunch, he would then have been locked in his cell. He would have been alone, as his cell mate was attending court.

Brixton has a system of ‘freeflow’, which allows prisoners to make their own way to, for example, work in the morning, and then back to the wing for lunch. Some of the gates are unlocked to allow this to happen, and staff are placed at various points along the routes. Morning freeflow operates from 11.30am to 11.45am, and the afternoon freeflow starts at 2pm. So at the time the man who died was returned to the wing, other prisoners were making their own way back to their wings.

One of the prisoners on freeflow, told my investigator that on 19 April, at about 11.30am or 11.45 am, he was on his way from G wing (where he was finding out about an education assessment) back to his own wing, C wing. As he came out of G wing he says he heard a prisoner shouting out of his cell window something like 'I'm going to slit my wrists – tell the Governor', or perhaps 'I have slit my wrists'. There was a prison officer outside at the time, supervising freeflow. The prisoner on freeflow who spoke to the investigator thought no more of this at the time but later, when he heard that a man had died, he decided to come forward. He says he discussed the matter with other prisoners later that afternoon, and another prisoner, said he, too, had heard shouting.

The second prisoner who heard the shouting told my investigator that he was returning to C wing from his educational assessment on G wing. He said he heard a prisoner shouting out of his cell window something like 'Gov, I've cut my wrists, I can't handle this no more'.

During the course of the investigation, both prisoners who spoke to my investigator were taken separately to the area outside G wing. The prisoner on freeflow who spoke to my investigator identified the man's cell (G2.24) as the one from where the shouting came. The second prisoner identified cells G2.19 to 21.

A Senior Officer on duty outside G wing. He has recently resigned from the Prison Service, having served as a prison officer for over six and a half years, for reasons unrelated to the death which is the focus of this report. This Senior Officer told my investigator that he did not hear a prisoner call for help. If he had, he would immediately have arranged for assistance to be provided.

My investigator also interviewed the prisoners who were in the cells next door to the man who died - cell G2.25 and cell G2.23. The prisoner in cell G2.25 said that, after he had had his lunch, he was locked in his cell and lay on the bed listening to music. He did not hear any noise from the man's cell, and was not aware that anything had happened until about 3pm, when prison staff unlocked his cell and explained that he had died.

The prisoner in cell G2.23 said he would have been unlocked from his cell some time between 11.30am and 12.15pm so that he could get his lunch, which he would have taken back to his cell. He did not hear the man shouting from his cell that day, or anything that would indicate he was in distress. The prisoner in cell G2.23 thinks he fell asleep after lunch, and woke at about 2pm when he heard an officer open the cell next door and call for assistance.

Events in the afternoon of 19 April

Staff normally break at 12.30pm and return at 1.30pm, when there is a briefing before prisoners are unlocked for the afternoon. That day, there was a problem with the roll count of prisoners. The Senior Officer, who had arranged for the man who died to share a cell with his new friend, says they counted three times on the wing, and then A wing and G wing staff swapped

and counted each other's wings. It was 12.50pm before the roll was correct. Staff were therefore later than normal in returning from their break, and there was little time for their usual briefing. One officer had four or five prisoners to pick up and take back to the induction unit. He went first to the cell of the man who died. When he unlocked the door, at about 1.55pm, he found the man facing the wall, with a ligature attached to the cell bars and around his neck. He stepped out of the cell and called for assistance. A second officer was on the landing, about five cells away, and came immediately. The officer who found the man lifted him, and the second officer cut the ligature with a 'big fish' knife. The officer who found him laid the man on the floor on his back. The second officer called for more assistance, and returned to the cell. Neither officer could find a pulse. The second officer began mouth to mouth resuscitation, without waiting for a face mask. The officer who found him started chest compressions.

The officer who found the man says that 1.55pm was the approximate time that he unlocked the cell. He did not look at his watch, as other matters were more pressing. He thinks that it was only three to four minutes before a nurse arrived, as he had by then completed a couple of sets of chest compressions.

A Senior Officer who had been on the first landing was the first to arrive in the man's cell. He had been standing on the first landing, ticking off prisoners for freeflow, when he heard the call for assistance. The Senior Officer that made the shared cell arrangements saw him running up the stairs. She asked another officer to take charge of the freeflow prisoners, and ran after him. She saw him grab a radio from another officer to make a code 1 emergency call to the control room. The control room received the call at 2.05pm. Code 1 is used in life threatening situations. The control room's task is then to call the member of healthcare staff on radio sign 'Hotel 6'. Hotel 6 should arrive rapidly, together with 'Hotel 3', whose task it is to make sure that emergency equipment is taken to the scene, and to act as the co-ordinator. The doctor should also be called on an emergency bleep.

The Senior Officer, who made the shared cell arrangements, was second to arrive on the landing shortly after the call was made. She always carries a first aid kit, and she gave the officer who cut the ligature a face mask.

Because free flow was in operation, many doors were open and this meant that staff were able to get quickly to the man's cell. Also because of free flow, there were only a few prisoners on the landing. The second Senior Officer to arrive says they were locked up so that they were not standing watching what was happening.

A nurse was the first clinician to arrive, as she was on the wing at the time. The log taken at the time shows this was at 2.07pm. She took over from the officer who found the man. The nurse in 'Hotel 6' that afternoon says she received the code 1 call at about 2.10pm and rushed over to G wing. (The log shows that she also arrived at 2.07pm.) She took over the chest compressions, together with the Physical Education Instructor (PEI), who is also a first aid instructor. The Senior Healthcare Officer (HCSO) was just

handing over as ‘Hotel 3’, and he arrived shortly after the nurse from ‘Hotel 6’ – he thought about three or four minutes after the code 1 call – bringing with him the emergency kit, including a defibrillator. (The log shows that he arrived at 2.10pm.) He came with the member of healthcare staff to whom he was handing over who facilitated their speedy arrival by unlocking gates on the way. The HCSO says that they passed some furniture out of the cell to make more room, and he attached the defibrillator which showed no electrical activity to the heart. Nonetheless, staff continued to attempt to resuscitate the man. The first nurse to arrive at the cell helped to keep the airway open while the officer who cut the ligature used the ambubag to continue putting in air.

The control room log shows that an ambulance was called at 2.11pm, and arrived at the prison at 2.17pm. The log taken at the cell shows that the doctor (who had been present at the man’s first reception health screen) arrived at 2.15pm. At about 2.19pm, she pronounced death and said that the resuscitation attempts should stop. The paramedics arrived at the cell at 2.20pm and confirmed the death.

The officer that found the man made a written statement immediately after the incident, as did the officer who cut the ligature and the Physical Education Instructor. The officer who was in the holding room during the training course also made a statement that day. None of the healthcare staff made statements at the time. The nurse from ‘Hotel 6’ made a statement about two weeks later.

A ‘hot debrief’ was held at 3pm, attended by 20 staff, and members of the care team were present. A healthcare debrief was held the following morning. Every single member of staff involved who spoke to the investigating team said they felt very supported by the prison and its governors after the man was found.

At 3.15pm, the cell was secured. The police arrived at 3.25pm.

Staff spoke to the prisoners in the cells adjacent to the man’s cell and explained what had happened. They were asked whether they wanted to move out of their cells and if they wanted to see a Listener. The prisoner in cell G2.23 did not want to take up either offer. Staff agreed that the prisoner in cell G2.25 could move to his friend’s cell, where he remained until the early evening.

A Listener at the prison told my investigator that he was sitting with the man’s cell mate on his return from court, when prison staff broke the news of the death. The Listener said that the cell mate was shocked by the news, as he had not seen anything to alert him to the man’s intentions.

The Governor published a notice to prisoners about the death, and these were distributed under cell doors. The prison arranged for all Listeners in the prison to attend G Wing so that they were available if prisoners wanted to discuss what had happened and were in need of support.

Breaking the news to the family

When the man arrived at Brixton, he chose not to give a next of kin contact. This meant that the prison had to ask the police to locate his next of kin. The Chaplain and the Duty Governor say they did this as soon as the police arrived in the prison that afternoon. The police broke the news of the man's death to his sister during the early hours of 20 April and she then told their mother.

The family say that the police left a number for them to contact the prison the next day. They say that the wait until morning, when they could find out what had happened, was very hard to bear. They also say that, when they did ring the number, it turned out to be wrong.

The prison nominated the Chaplain to be the liaison point with the family. He spoke to the man's mother on the telephone later that day and agreed to be with the family on 21 April when they went to see the body. The family came into the prison the following Saturday, 23 April. The funeral was held on 29 April, and the family asked the Chaplain to take the service and attend the wake. The family say that they were not aware that the Chaplain was intended to be their ongoing main point of contact after the funeral.

Post Mortem

The post mortem report concludes that the cause of death was suspension. The ligature was made from a sheet cut with a razor blade. The report says there were no known suspicious circumstances, and no note was found.

Clinical review

The clinical review looked in more detail than my investigation, and from a clinical perspective, at the adequacy of the health care that the man received at Brixton, during both the reception process, and after he was discovered hanging in his cell. The review concludes that the clinical management of the attempt to resuscitate the man was exemplary.

However, he identifies some concerns about the medical care the man received on reception into Brixton:

- He concludes that there is lack of clarity about when and how a referral for a mental health assessment is made, once the initial heath screen identifies that such a referral is required, and about the role of the doctor in that process.
- He says that there was uncertainty as to what was meant by a 'mental health assessment' – whether this was something that should be done by a nurse, the doctor on reception, or a psychiatrist from the Outreach Team.
- He is critical of the fact that the initial health screen form was not properly completed.
- He is concerned that neither the nurse nor the doctor on reception appeared to have the skills required to make an adequate assessment of mental health or the risk of deliberate self harm. He also concludes that Brixton does not have a system to ensure that healthcare staff have adequate training to assess mental health or suicide risk, beyond the ability to administer the first reception health screen.
- He raises the lack of any system for making sure that important documents, such as the Forensic Medical Examination Form, are seen by medical staff.

Conclusions

It is clear that, in the short time that the man was in Brixton, he gave neither staff nor his cell mate any obvious indication that he was likely to self harm. Throughout the reception and induction process, although he may have been understandably unhappy, he presented as someone who was not overly distressed. However, people intent on self harm do not always advertise how they feel. That makes it even more important that any warning signs are identified and acted upon, and that relevant information is shared between agencies.

In the man's case, police officers had information from their interview with him that suggested that he might have had mental health problems, but this was not passed on to Brixton.

Recommendation: I recommend that the Prison Service and the Association of Chief Police Officers together draw up a memorandum of understanding to ensure that all relevant information about a prisoner is passed from the police to the Prison Service.

In the man's case, it might also have been helpful if the police medical assessment had come to a clear conclusion about the signs of paranoia that he was showing. I am glad that the police are conducting their own investigation into this issue.

When he was interviewed by medical staff in reception, he gave another small indication of his vulnerability by revealing that he had self harmed in the past. I am critical of the way that Brixton dealt with this information. First, medical staff should have made a proper note at the time of the details of the incident. It is not acceptable that we now have to rely on staff recall of what exactly the man might have said, and that no one can be sure what actually happened that evening.

Recommendation: I recommend that the Governor, in concert with the PCT, reminds healthcare staff of the need correctly, and fully, to complete the first reception health screen, and ensures that monitoring is part of the clinical audit cycle.

Brixton's own procedures required that, as the man had self harmed in the past, he should have been referred for a mental health assessment. There are differing accounts from the nurse and the doctor on duty as to what may have happened, with the nurse saying there was, in effect, mutual agreement between them that no assessment was needed, and the doctor saying the case was not formally referred to her. There is no note in the medical record to explain what decisions were taken, by whom and why. My view is that Brixton should make it clear exactly how the referral should be made, whose responsibility it is to do the assessment, and what such an assessment involves. Procedures should also be put in place to ensure that a note is made in the medical records of all decisions taken, and the reasons for them.

Recommendation: I recommend that the Governor and the PCT review the arrangements for making mental health referrals and carrying out mental health assessments on reception.

The clinical review, on behalf of South Lambeth Primary Care Trust, makes similar, more detailed recommendations, which I fully endorse. The review also recommends an urgent review of the training of healthcare staff, to ensure that they all have the appropriate skills and knowledge to assess the risk of suicide and deliberate self harm. It takes the view that Brixton should also decide whether healthcare staff should receive training to be able to carry out a wider mental health assessment and, if so, at what level. My view is that these are important recommendations, which should be implemented as soon as possible.

Recommendation: I recommend that the Governor and the PCT undertake a training needs analysis of healthcare staff to identify the skills required to assess the risk of suicide and self harm, and to decide on the level of mental health assessment they should be able to make.

The review says that all medical officers should have knowledge and skills in assessing the risk of suicide and deliberate self harm, at least to the level of a competent General Practitioner. It recommends that assessment of these skills should be part of the appointment process, and that doctors without these skills are either offered training or required to organise their own. Again, this is a recommendation that I fully support.

Recommendation: I recommend that the Governor and the PCT review the appointment process to ensure that all medical officers have adequate knowledge and skills in assessing the risk of suicide and deliberate self harm, at least to the level of a competent General Practitioner.

I have some additional concerns about the man's medical care on reception. He was asked if he wanted to see a doctor, and he declined. Brixton's guidance says that, in these circumstances, a signature must be obtained from the prisoner. His signature was not obtained. I do not want to add unnecessarily to the number of formal recommendations in this report, but the Governor and the PCT will together wish to ensure that medical staff do obtain the prisoner's signature if he decides he does not want to see a doctor. The first reception health screen form should perhaps be redesigned to facilitate this.

There is now no way of knowing whether medical staff had the police Forensic Medical Examination forms, and took account of them in their assessment of the man who died. The nurse who interviewed him did not recall seeing them, and it seems that they do sometimes arrive later. My view is that both prison and medical records should make it clear what information has been received and taken into account when assessing a prisoner's health. Again, this is something the Governor and the PCT should jointly consider. For example, a checklist of documents arriving with a prisoner could be produced, to be

completed before the prisoner goes through the first reception health screen. Medical staff could then indicate what documents they have taken into account when making an assessment. Again, this might involve a redesign of the first reception health screen form.

Finally, the heath care guidance about the reception process is out of date, and tells staff how to fill out a heath care screening assessment that no longer appears to be in use at the prison. The Governor and PCT will wish to make sure that medical staff are provided with up to date guidance on the reception screening process.

It is clear that, quite apart from the medical care in reception, the reception process overall at Brixton is not entirely satisfactory. I am glad that the prison is taking steps to see what improvements can be made.

I have some concerns that it seems no Listener was on reception on 18 April, and possibly also at the induction programme the next day. But I am satisfied that the man who died would have been told about the availability of Listeners during the induction process, and so he would have known that the service was available to him.

Recommendation: I recommend that the Governor reviews procedures to ensure that Listeners are always available on reception and induction.

I turn now to events on 19 April. I do not know exactly what happened during the morning freeflow, but I am satisfied that, if prison staff had heard him shouting out of his cell window about cutting his wrists, they would have taken action to help him. I also take the view that the fact that there were several counts of prisoners that lunchtime, in order to get the roll correct, means that he must have been well at least up to about 12.50pm, when the roll was agreed.

Once he was discovered, staff made all reasonable efforts to save his life. In the clinical review, its that the clinical management of the attempt to resuscitate the man was exemplary. I also particularly commend the actions of the man who cut the ligature and aided the attempted resuscitation, who went above the call of duty in his efforts to save the man who died.

I am impressed, too, by the support provided by the prison to both staff and prisoners after the man's death.

Recommendation: I recommend that the Governor draws to the attention of all those who took part in the attempted resuscitation of the man both the comments of the clinical review and my own commendation of their efforts, and particularly thanks the officer who cut the ligature and aided the attempted resuscitation for the action that he took.

I do, however, have concerns that an ambulance was not requested as soon as the code 1 emergency was called. The Prison Service told all governing

Governors in March 2004 that it was essential that internal procedures should not result in wasted time before summoning emergency assistance, for example, by insisting in every case that a member of healthcare attend the emergency before the ambulance is called. Brixton's 2003 contingency plans for dealing with a death of a prisoner (which are the most current) require that the ambulance be called immediately, but the more recent healthcare protocols suggest that a clinical assessment should first be made. It is the more recent protocols that the prison followed once the man was found.

I am also critical of the fact that no statements were taken from healthcare staff in the immediate aftermath of his death. While in this case it is clear that all that could have been done was done, it is important that staff make a note at the time of exactly what happened. This means that events can subsequently be scrutinised on the basis of contemporaneous accounts, and not on the basis of what staff recall some days or weeks later.

Recommendation: I recommend that the Governor reviews and updates the contingency plans and the healthcare protocols to make sure that they are in line, and make it clear that, when there is a code 1 life threatening emergency, an ambulance should normally be called immediately. I also recommend that the Governor ensures that proper arrangements are in place for taking statements from healthcare staff, as well as discipline staff.

I know that the family are unhappy about the way the news of the man's death was broken to them. However, the man did not provide any details of his next of kin, and it seems to me that it was appropriate for the prison to ask the police for help in locating his family. Given the delay that had already and inevitably occurred, it was also probably sensible then to ask the police to break the sad news in the early hours. Nonetheless, it seems to me that it cannot be right that the family then faced an agonising wait until the next morning before they could obtain any details of what happened. I do not know whether, in this case, the communication problems were caused by the prison or the police. I should stress, however, that I consider it good practice for the prison to give the police an immediate contact number for the family, so that they can talk to the duty governor or the family liaison officer at the earliest opportunity. It is also good practice for the prison family liaison officer to confirm their role in writing to the family, so that the family is clear about the nature of support that is on offer.

Finally, the clinical review identifies a number of additional learning points for the prison, which I fully endorse.

Recommendations

National

Recommendation: I recommend that the Prison Service and the Association of Chief Police Officers together draw up a memorandum of understanding to ensure that all relevant information about a prisoner is passed from the police to the Prison Service.

Local

Recommendation: I recommend that the Governor, in concert with the PCT, reminds healthcare staff of the need correctly, and fully, to complete the first reception health screen, and ensures that monitoring is part of the clinical audit cycle.

Recommendation: I recommend that the Governor and the PCT review the arrangements for making mental health referrals and carrying out mental health assessments on reception.

Recommendation: I recommend that the Governor and the PCT undertake a training needs analysis of healthcare staff to identify the skills required to assess the risk of suicide and self harm, and to decide on the level of mental health assessment they should be able to make.

Recommendation: I recommend that the Governor and the PCT review the appointment process to ensure that all medical officers have adequate knowledge and skills in assessing the risk of suicide and deliberate self harm, at least to the level of a competent General Practitioner.

Recommendation: I recommend that the Governor reviews procedures to ensure that Listeners are always available on reception and induction.

Recommendation: I recommend that the Governor draws to the attention of all those who took part in the attempted resuscitation of the man both the comments of the clinical review and my own commendation of their efforts, and particularly thanks the officer that cut the ligature and aided the attempted resuscitation for the action that he took.

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