Circumstances surrounding the death of a man, a prisoner at HMP Brixton, at Kings College Hospital, London, in April 2006

Report by the Prisons and Probation Ombudsman for England and Wales

June 2008

This is the report of an investigation into the circumstances of the death of a man at Kings College Hospital, London, on 28 April 2006, while a prisoner at HMP Brixton. The man had been mentally ill for a number of years, and was located in the healthcare centre at Brixton for the duration of his time there. On 7 March 2006, he was found hanging in his cell. Cardio pulmonary resuscitation was carried out and he was taken to hospital. The man did not return to prison and died seven and a half weeks later. A post-mortem gave his cause of death as 1a) bronchopneumonia, 1b) hypoxic brain injury and 1c) suspension. At the time of his death, the man was 33 years old.

I would like to offer this public expression of condolences to the man's family and friends on their loss. A key objective of all my investigations is to ensure that the bereaved family has the opportunity to raise any concerns and contribute to my inquiries. The man's family and solicitors raised a number of matters with one of my Family Liaison Officers. I hope my investigation begins to offer answers to these questions.

The investigation was led by my colleague. A clinical review was conducted a General Practitioner, on behalf of Lambeth Primary Care Trust. I am grateful to the General Practitioner for his review and careful consideration of the issues. I also thank the Governor and staff at HMP Brixton for their co-operation with this investigation. In particular, I am indebted to the establishment's liaison officer.

This investigation has revealed a particularly troubling aspect of the man's care. Four hours prior to being found hanging, he had set fire to his right trouser leg and suffered minor burns. He was placed on suicide and self-harm monitoring and observed on an intermittent watch. The cell in which the man was located had dual use, allowing it to be used as either an ordinary cell or a gated one. At the time, the cell door was defective and the gate was used instead. Staff did not consider the implications of placing a prisoner at risk of self-harm in a cell with an increased number of ligature points. The man was found hanging from one of the gate's bars.

I am critical of placing a prisoner deemed at risk, but not regarded as being in need of constant supervision, in a gated cell. My report and the clinical review, contain a significant number of recommendations.

Stephen Shaw CBE
Prisons and Probation Ombudsman **June 2008**

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SUMMARY

On 28 September 2005, the man received a five year sentence for robbery. He had been on remand for seven months. For much of the time, the man was in HMP Pentonville, although he also moved to other establishments.

The man had a long psychiatric and offending history. At the beginning of November 2005, he was on ordinary location at Pentonville. However, his demeanour was giving staff cause for concern. On 3 November, the consultant psychiatrist assessed the man and requested his admission to the healthcare unit for observation. However, Pentonville's healthcare unit was undergoing refurbishment and the man was therefore transferred to HMP Brixton on 4 November.

Upon reception at Brixton, the man was immediately placed in the healthcare centre where he remained for the duration of his time at the prison. He proved very difficult to manage during his first few days at Brixton, and following an attack on a member of staff he was placed on a three man unlock. The man was assessed to be acutely ill at the time and the consultant psychiatrist was unhappy about the move. He immediately initiated procedures to have the man assessed and transferred to a secure psychiatric hospital. However, the hospital's visiting psychiatrist did not agree with his assessment. The consultant psychiatrist sought a second opinion. This again did not concur with the view of the consultant psychiatrist and the medical team at Brixton.

The man was relatively stable at times, but for other periods was difficult to manage and unpredictable. He was often non-compliant with his medication which in turn impacted on his behaviour, and he was often placed on a three-man unlock.

On 6 March 2006, the man pulled his toilet off its hinges in his cell. He was transferred to another cell, D1-01. This cell had dual use and could be used as either an ordinary one or as a gated cell. At the time, the cell door was defective and the gate was being used.

At 6.35pm on 7 March, the man set fire to his trousers leg after he had stuffed it with newspaper. The fire was put out quickly with an extinguisher and the man was moved upstairs to another cell, D2-01, whilst D1-01 was cleared up. However, another prisoner was taken ill and staff needed cell D2-01 for this man. The man was moved back to cell D1-01. Again, the gated door was in place.

Following the fire, the man was placed on a F2052SH (suicide/self-harm monitoring arrangements). The decision was made to observe him intermittently, six times an hour. At 10.20pm, the man was found hanging from the gate. Cardio pulmonary resuscitation was conducted, initially by prison staff, and then by paramedics and doctors from Kings College Hospital.

Having been taken to hospital, the man regained consciousness some days later and was well enough to be moved to a ward. Sadly, he suffered a relapse and died on 28 April.

THE INVESTIGATION PROCESS

1. My investigator conducted a preliminary visit to HMP Brixton on 10 May 2006 and visited the cell in the healthcare centre where the man was found hanging. All the documentation was reviewed and a chronology of events established.

2. Notices were issued to staff and prisoners telling them of the investigation and offering the opportunity to speak with my investigators. No one came forward as a result. My investigators met with representatives of the local branch of the Prison Officers' Association (POA) and the chairman of the Independent Monitoring Board (IMB).

3. Nineteen members of staff, both discipline and healthcare, were interviewed on tape at Brixton by my investigator. On behalf of the Primary Health Trust, a General Practitioner, undertook a clinical review of the healthcare provided for the man at HMP Brixton. Joint interviews were conducted whenever possible.

4. During the initial visit to Brixton, my investigators asked nursing staff about interviewing the prisoners who had been in the cells adjacent to the man. They were told that the three prisoners in question had been transferred to outside hospitals. This was confirmed by cross-referencing prison records.

5. On behalf of the London Area Manager of the Prison Service started an internal investigation following the events of 7 March. This was in response to the policy in operation at the London Area Office, which is to commission an inquiry into any act of serious self-harm. At the onset of the investigation, the man was still receiving ongoing treatment as an in-patient at hospital. The enquiry was completed by the time of the man's death. My investigators met with the internal investigator and have received a copy of his report. I am most grateful to him.

6. My investigator met with a detective inspector and detective sergeant of Brixton CID on 10 May 2006 and liaised with them throughout the investigation. The detective inspector provided my investigators with a copy of the police report.

7. One of my Family Liaison Officers made contact with the man's family, offering the opportunity to meet with the investigator. My investigator and family liaison officer met with the man's two sisters at the offices of the solicitors appointed by the family.

8. Feedback from the investigation was provided to the Governor of Brixton on a regular basis.

9. A draft version of this report was sent to the prison service. An action plan was provided in response. The Prison Service indicated whether they accepted the recommendations or not. The responses can be found under the recommendations section of this report and have been reproduced verbatim.

10. In addition, changes have been made to paragraphs 28 and 79 at the request of the prison service. A number of requested changes to the clinical review were not made as the author of the review, did not agree with them.

11. The man's family and their solicitors were sent a copy of the draft version of this report. They raised a number of matters, all of which were dealt with by way of letter.

HMP BRIXTON

12. Brixton is a local prison, mainly serving the Inner London and Southwark Crown Courts. It holds remand and convicted prisoners. There are four main residential units and a healthcare centre (HCC). The man was located in the HCC for the duration of his time at Brixton. At the time, the HCC (also known as D wing) had capacity for 36 patients, 18 in single cells and 18 in shared accommodation. Seven cells are fitted with metal toilets and sinks and reinforced mattresses for the management of patients who exhibit disturbed behaviour. Prisoners with physical health problems are also housed on D wing.

13. There are three levels on the HCC, the 1s, 2s and 3s. Level 1, which had four single cells, was generally used for the most severely mentally ill. Those in the 3s were usually the most stable. There were no safer cells (cells with reduced availability of ligature points) on the wing, although all the cell furniture was secured to the ground. There were exposed bars on the cell windows.

14. When the man was on D wing there were two gated cells on level 1, D1-01 and D1-02. These two cells had the dual function of being a normal cell or a gated cell. They both have an ordinary cell door which can be locked back against the cell wall when not in use, and a gate which can be locked. The gate then operates as both a locked barrier as well as providing a means by which to observe the occupant at all times if necessary. D1-01 was immediately to the right at the bottom of the stairs.

15. HM Chief Inspector of Prisons, Ms Anne Owers, carried out an unannounced full inspection of Brixton between 22 February and 3 March 2006. In her report published in May 2006, Ms Owers described the healthcare arrangements in the following terms:

> '… healthcare in-patient wing – supposedly a six-month temporary solution – was still in operation two years later, in spite of its manifest inadequacy. There was only a limited regime, too much reliance on agency nurses, and the basement area, holding the most severely mentally ill patients, was wholly unacceptable: with cold, concrete floors and graffiti-covered walls. This was exacerbated by delays in transferring patients to appropriate NHS mental health facilities: at the time of the inspection, 11 prisoners were awaiting transfer, and at least another five were awaiting assessment.'

16. Regarding the cells on the basement area (level 1), one of which the man occupied the night he hanged himself, Ms Owers wrote: 'the cells on the ground floor of D wing should be condemned immediately'. Contemporaneous notes of feedback given to the then Governor and all senior managers on 3 March describe the unit as being 'not fit for purpose'. On 24 April 2006, On 15 May 2006, the Governor took the cells out of use. Two cells on level 2 of D wing were modified to be used as gated cells when needed.

17. In her report, Ms Owers also recommended that: ‘A purpose-built in-patient facility should be provided as a matter of urgency. Mental health staff should be consulted about the new building to ensure that it is fit for purpose.’

18. Including the man, there were five deaths at Brixton during 2006, all of which have been investigated by my office. These are all still awaiting inquests. Two are regarded as deaths by natural causes and three were apparently self-inflicted. Of those who died apparently at their own hand, the man was the only one to have been located in the HCC. Reviewing my other investigations, there appear to be no issues of specific relevance to the circumstances of the man’s death.

19. Lambeth Primary Care Trust became formally responsible for the healthcare provision at HMP Brixton in October 2005. The prison health partnership board has responsibility for monitoring the delivery of services under the clinical governance arrangements.

20. On 21 August 2006, Brixton introduced the Assessment, Care in Custody and Teamwork (ACCT) system for monitoring and supporting those at risk of self-harm and suicide. This replaced the F2052SH.

KEY FINDINGS

21. The man was seen for a psychiatric review on 3 November 2005. This indicated that he was having a relapse of his psychotic illness and that he needed to be moved to the healthcare centre for further assessment. It was also recorded that the consultant psychiatrist had been approached by a fellow prisoner (who said he was a friend of the man's) who was very concerned about the man's recent deterioration in his mental health.

22. On 4 November, following the closure of the healthcare centre at Pentonville, the man transferred to Brixton. A note in his medical record, dated 3 November, said that the man had been accepted by principal officer on D wing, and a Consultant Forensic Psychiatrist at Brixton.

23. The consultant psychiatrist reviewed the man's history following his arrival. He recorded that the transfer was not discussed or agreed with him and that transfer 'at this stage of his treatment is highly inappropriate'. The consultant psychiatrist referred the man to a local NHS Mental Hospital, for assessment and with a view to his admission as an in-patient. This was followed on 12 November by a letter from the staff nurse to highlight the impact that the man was having on the nursing staff.

24. The man was admitted to D wing. His first days at Brixton were difficult. He was said to have been laughing inappropriately, being constantly noisy throughout the night, and refusing his medication. His personal hygiene was also poor, and the man was noted to have urinated and defecated inappropriately on 8 November. Following an assessment on the same day, the consultant psychiatrist repeated his criticism of the transfer, saying that 'it happened without clinical discussion' and that he 'would not have accepted him for transfer had this been discussed in advance'. It is unclear how the discrepancy between the account given by the consultant psychiatrist and the written notes referring to the principal officer on D wing occurred.

25. At around 6.05pm on 8 November, the man attacked three members of staff on the stairs of D wing and had to be physically restrained. Immediately prior to this, he had been 'howling' during the association period and staff had attempted unsuccessfully to calm him down. The man was subsequently placed on a three man unlock, meaning that three members of staff had to be present each time his cell was opened. This had the effect of restricting the amount of time he was able to take part in out of cell activities.

26. The man's behaviour continued to deteriorate and he was refusing his medication. During the afternoon of 12 November, he flooded his cell (D1-03) with water and excrement. As a result, a decision was made to forcibly medicate him, under common law, and the man moved cells to D1-04.

27. During the evening of 19 November, the man moved cells to D1-01 after a 'fire incident' in D1-03. There are no further details given in the records. By 21 November, he had improved a little, although was still refusing to take his

medication and a decision was made to try removing the three man unlock during an exercise period. This trial went well.

28. At around 9.40pm that evening, however, the man flooded his cell after demanding a phone call and to see the duty governor. He spoke to a Listener (a prisoner who has been trained by the Samaritans to offer support) later that evening, and was recorded to be more settled through the night.

29. The man moved cells from D1-01 to D1-02 on 25 November. The reason for this move is not recorded. On the following afternoon, the three man unlock was fully rescinded as the man's behaviour had become more settled in the preceding days. The following conditions were imposed:

    - The man should comply with his medication.
    - He should show settled behaviour, without resorting to aggression.
    - He should make an effort to communicate with staff.

33. Two hours later, the three man unlock was reinstated. The man had been 'howling' and laughing loudly in his cell, and had been accusing staff of holding him illegally. According to an entry in the medical record, staff was unable to communicate with the man 'in any meaningful way'.

34. The man moved back to cell D1-01 on 1 December. He had become more settled, although was still prone to shouting during the night. He was now complying with his medication. On 2 December, he was assessed by a Consultant in Forensic Psychiatry from the local mental hospital. The consultant psychiatrist wrote in the man's Medical Record: 'I judge his PD (personality disorder) as untreatable' and said that she was 'very reluctant to consider him for hospital transfer'. She confirmed this opinion in a letter to the consultant psychiatrist at the prison on 15 December.

35. The man's behaviour continued to be unpredictable throughout December. Although he was often noted to be quiet and settled, there were also a number of occasions in which he was reported to be shouting and banging throughout the night or asking staff to let him go home. In particular, on 10 December he threatened to 'cut up' members of staff. On 22 December, he was moved from cell D1-01. He flooded his cell on both 24 and 25 December.

36. The consultant psychiatrist at the prison did not agree with the consultant psychiatrist from the local mental hospital's conclusions in her assessment of the man on 2 December. At the management round of 6 December, he remarked that he considered the view that the man was untreatable to be unacceptable. After a review on 3 January 2006 at which he noted that the man had improved considerably, the consultant psychiatrist from the prison referred the man to the local mental hospital for a second opinion.

37. The man continued to improve through January, and on 10 January it was decided again to take him off the three man unlock. He was relocated to D3-08 on 23 January. At a review the following day, the consultant psychiatrist noted

that the man was 'generally compliant and settled, but easily aroused and agitated'.

38. At a ward round on 27 January, the man was noted to be refusing to take Clopixol (an anti-psychotic drug) on account of the side effects. The consultant psychiatrist recorded that the man was engaging and polite at interview, and displaying no current psychotic symptoms. The consultant psychiatrist considered that the man 'clearly has the capacity to make decisions re treatment at present', and that he was unable to opt for compulsory treatment. He therefore agreed to discontinue Clopixol and start the man on Aripiprazole (another anti-psychotic drug) as an alternative.

39. The man remained settled over the next week. On 30 January, he spoke to a Samaritan on the telephone, and on 1 February he was seen by a Listener. On 7 February, the man complained of hearing voices especially at night. He said that the voices were derogatory but did not issue commands, and that he felt scared. The man said that he had no thoughts of self-harm or suicide at this time. By 10 February, the man said that he was hearing voices all day. He asked for an increase in Aripiprazole to counter this. This was agreed by the senior house officer in psychiatry.

40. The man again settled for about a week. At around 11.30pm on the night of 18 February, he asked to see a Listener. This request was refused by the healthcare officer as the man had refused to go back to his cell earlier that evening when told to do so. The healthcare officer recorded that he was 'most reluctant to put my colleagues at risk in a potentially dangerous situation'.

41. On 20 February a second consultant psychiatrist from the local mental hospital assessed the man. The second consultant psychiatrist acknowledged the man's complaints of hearing voices, but did not consider that he had demonstrated behavioural disturbance. He concluded that the man did not require transfer to hospital.

42. During the course of the next week, the man began to display signs of paranoia. On 22 February, he accused two members of healthcare staff of taking bribes to keep him in prison. An entry in his medical record on the same day noted that the man had shown a 'rapid decline in mental health state in the last 24 hours' and that 'there is clear evidence that he is relapsing'. The man was later examined by the senior house officer in psychology. During the examination, he repeated his paranoid thoughts but expressed no thoughts of suicide or self-harm. After a lengthy conversation, the senior house officer persuaded the man to take his medication.

43. On 23 February, the man was noted to be 'very subdued' and 'very paranoid'. He was described as 'still very psychotic' on 26 February, and this was attributed to his depot (an injection of drugs) being stopped. Telephone records indicate that the man made his last phone call on 27 February.

44. The man was assessed by the specialist registrar in psychiatry at Brixton, on 28 February. The specialist registrar described the man as 'paranoid,

argumentative and with persecutory delusions'. The man listed to the specialist registrar up to 50 people whom he believed were conspiring to keep him in prison. He again reported hearing voices, but said that they were better. The specialist registrar decided to write the man up for depot Clopixol. This was supported by the consultant psychiatrist at the ward round that afternoon. The consultant psychiatrist agreed that the man was 'clearly psychotic'. The management round notes for that day record:

> "Paranoid and expressing persecutory ideas about staff. Thinks staff are working with the police to keep him here unlawfully. Thinks the judge and solicitors are fake. Action: re-start his depot and encourage compliance."

45. The man continued to appear psychotic and challenging to staff over the next few days. On 4 and 5 March, however, he was noted to be settled and pleasant and had been engaging in cleaning duties with enthusiasm. On 5 March, it was noted that the man 'appears to be mentally stable'.

46. At around 12.30pm on 6 March, the man lifted his cell toilet from its hinge. The nurse in charge of D wing described the man as being 'very paranoid'. Given the state of the cell, the man was not able to remain there and was moved to cell D1-01 which was used with the gate in place. In her interview, the nurse said that the man's behaviour probably justified him being placed in that cell, but she could not recall whether there were any other cells available.

47. In response to being asked about how cell D1-01 was being used, the nurse said:

> 'I don't think it was condemned at that stage, it still, I mean I remember the door wasn't, there were still problems with the door. But it still had a, I think it still had a gate. But it wasn't, at the time it wasn't condemned. At the time, I think that was only as a last resort, really ... The gate was, I think, was in use.'

48. It was noted in his medical record that the man 'remains paranoid at times and challenging'. Later that afternoon, the man was assessed by the senior house officer. He complained of anxiety and insomnia, and the senior house officer thought that he looked very distressed. The man said that he had no thoughts of self-harm at the time. At around 6.30pm, he was seen by the staff nurse and asked to have some talcum powder on his head. At interview, the staff nurse said that he took this as an indication that the man was still quite disturbed or unwell. The record of cell bells for the day shows that the man pressed the cell bell at 2.56 pm, 3.39 pm, 8.23 pm, and 11.36 pm. All were answered fairly promptly.

7 March

49. The man then had an unsettled night. At midnight, he was demanding medication and shouting at the top of his voice. He was given Haloperidol 10mg (an anti-psychotic) at this time. At around 3.30am, he demanded to be released

with immediate effect. An entry in his medical record at the end of the night said that he had been pressing his cell bell constantly and demanding to be taken to the prison reception area to be released. Records show he pressed his bell at 3.41am, 4.03am, 5.04am, 6.57am, and 7.56 am. On the whole, these were answered promptly, except the last one which appeared to have been answered after 40 minutes.

50. The man was one of 20 prisoners seen on a ward round at around 3.00pm on 7 March. In his written assessment following the round, the senior house nurse noted that the man was on three man unlock. The documentation does not give any reason for this, but the man's actions the previous day may have prompted staff to place him on this restriction. His status would have been reviewed after 24 hours. The man was noted to be continuing to express paranoid delusions about particular officers and continuously demanding his release. The senior house nurse recorded the view of the Forensic Liaison Nurse that 'he should not continue in the prison and needs to be transferred out'. A decision was made to 'increase the man's depot, and that he should remain on D wing'. The nursing notes record, 'appears to be deteriorating. Thinks staff are taking bribes to keep him incarcerated. Paranoid about some staff.'

51. In interview, the staff nurse recalled seeing the man standing at the gate of cell D1-01 when he returned from the management round. He recalled the man asking about having a shower and whether he was going to be on a three man unlock because of 'what he did'.

52. The man rang his cell bell on a number of occasions during the afternoon of 7 March. An entry in his medical record at 4.40pm said that the man:

> '… appeared very restless and agitated due to the fact that he has been placed on a three man unlock. Most of his statements are incongruent and has been very paranoid about staff. Has been eating and drinking well but was refused association due to a limited number of staff on the wing.'

53. A nurse recalled speaking with the man that afternoon. She said that the man had wanted to come out to collect his dinner which she allowed him to do. She said that at this time he was calm.

54. She returned to the cell a little while later and noticed that the man was putting his fingers in his ears. The nurse asked the man why he was doing this and he said that he could hear voices and wanted to block them out. The nurse was worried about the man and at around 6.30pm decided to open a F2052SH (the form used at the time by the Prison Service to monitor prisoners deemed at risk of suicide or self-harm). The nurse wrote in the nursing assessment section of the form: "Complained of hearing voices. Requested help, needs more medication. Had fingers in his ears to block out voices. Frightened and anxious." She placed the man on 'Intermittent Supervision' (IS), meaning that he would be observed at random intervals averaging once every ten minutes.

55. At around 6.35pm, whilst the nurse was completing the F2052SH, the man set fire to the right leg of his trousers after stuffing both legs with newspaper. He was discovered by a healthcare assistant after he heard shouts and went down to the 1s. He saw smoke coming out of the man's cell and immediately called to a second nurse, who was in the staff office on level two, for assistance. The second nurse collected the fire extinguisher from a third nurse and ran down to the cell. The healthcare assistant opened the man's cell, and the second nurse entered and extinguished the fire.

56. The man was then moved to cell D2-01, and a doctor was called. A doctor from reception attended and assessed the man. He concluded that the burns were superficial and red, but not blistered. He asked the nursing staff to apply Flamazine cream (an antibiotic used to treat and prevent infections at the site of burns). He also prescribed a course of erythromycin (an oral antibiotic) to be used if necessary.

57. In interview, the reception doctor recalled that the man had said that he had accidentally set fire to his leg. He said that he was not made aware of the man having stuffed newspaper down his trousers. At the time, the reception doctor was not asked to make an assessment of the man in terms of his mental health by any member of healthcare staff. However, in interview he recalled the man as:

> "… lucid and the fact that he could answer my questions, and he wasn't being held down, he wasn't making things up, there was no sort of delusional quality to his speech … I made an assessment that he wasn't delusional at the time when I saw him, he didn't seem particularly agitated, because obviously I would definitely have commented on that."

58. The third nurse completed form F213SH (a form used to describe incidents of self-harm or attempted suicide), and the reception doctor countersigned it. The nurse remembered that the man kept on saying 'I am sorry'.

59. The duty governor was called to healthcare. In interview, he said that he established that a F2052SH was opened and then left D wing. He did not speak directly to the man.

60. The healthcare assistant remained with the man until around 8.00pm. The man was calm and very apologetic during this time and the healthcare assistant provided reassurance. At about 8.00pm, the man was moved back to cell D1-01 as another prisoner who was unwell needed to be in D2-01 due to its proximity to the wing office. In interview, the nurse said that the man had asked to go back to cell D1-01. Intermittent supervision began at this time (six checks an hour), and D1-01 was again used as a gated cell.

61. The third nurse made entries in the man's supervision record at ten minute intervals from 8.00pm until 8.50pm inclusive. Three observations record 'standing at gate'. The entry at 8.20pm says 'asked for a light', and at 8.30pm it says 'smoking stood at gate'.

62. At around 8.45pm, the night staff took over on D wing. The nurse in-charge, with callsign Hotel 3, and the emergency response nurse. They were based on D wing, but would respond to medical emergencies and other healthcare duties throughout the prison, which often took them off the wing for long periods of time. A prison officer and the healthcare assistant were stationed on D wing throughout the night.

63. The staffing levels are detailed in the Healthcare Centre Operating Procedures. At night, the optimum staffing levels for D wing are one desk officer, three nurses and one healthcare assistant. On 7 March, there were only four staff. The reason for this is not known.

64. The night staff received a handover at the start of their shift. At interview, the nurse in charge said that he was told about the fire incident at the handover and that the man was now on intermittent observation and settled. He said that the night staff were told that if the man became restless they should put him onto constant supervision.

65. In interview, the emergency response nurse recalled being told about the fire incident and that if necessary he should be put on constant supervision. After the handover, she recalled speaking to the man as she walked passed D1-01 on her way to the treatment hatch. He was polite and calm and different from how she had seen him the night before. Some time after 9.00pm, the nurse in charge and emergency response nurse both left the D wing. The emergency response nurse said that she left the wing in response to a call for Hotel 6 and that the nurse in charge went with her.

66. The nurse remembered speaking with the man as she was leaving at the end of her shift some time after 9.00 pm. She said that she put her hand on the rail and he took his hand and put it over hers: "…and he was saying that he was very sorry. I said to him 'stop apologising', I like it that he is well and I will see him tomorrow and he said 'alright'."

67. The prison officer wrote an entry in the F2052SH at 9.00pm: 'Speaking to [the man] and he was requesting diazepam. (Told he will see the doctor am), given a cigarette and no self-harm observed.' (In interview, the prison officer was asked whether he was sure that it was diazepam and not lorazepam that the man asked for. Lorazepam was one of the medications that the man was on. The prison officer said it could have been lorazepam.)

68. The prison officer spoke to the man about the fire, and said that he would put him down to see the doctor in the morning. He also gave the man a cigarette when he asked for one. The nurse in charge also recalled the man requesting diazepam at this time. He told the man that he could not give him diazepam as he was not written up for it, but that he would put him down to see the doctor in the morning.

69. The healthcare assistant carried out the intermittent observations on the man from 9.00pm onwards. At each interval through to 10.20pm inclusive, he was

recorded as either ‘standing at gate’ or ‘sitting on bed’. The man also pressed his cell bell three times (at 9.21pm, 9.32pm and 9.36pm). It is not clear what the man wanted on these occasions, although the healthcare assistant recalled him asking if the nurse would be working the next day.

70. When making his check on the man at 10.10pm, the healthcare assistant asked him if he was all right and whether he would like a drink. The man nodded and said that he did not want a drink. He then sat down on his bed, silently. The healthcare assistant carried on with his rounds.

71. Around ten minutes later, at approximately 10.20pm, the healthcare assistant returned to the man’s landing to make his next check. At interview, the healthcare assistant said that, when he reached the foot of the stairs, the man appeared to be standing and resting against the bars. He therefore made the entry ‘standing at the gate’ in the record. However, he saw no movement from the man and therefore went to have a closer look at him. The healthcare assistant then saw that the man had made a thin ligature from a strip of bedding and had tied it around his neck and to the bars of his cell. At this time in the evening, the light on the wing landing was out and the place was quite dark.

72. The healthcare assistant immediately called the prison officer for assistance. He ran downstairs from the office, opened the cell using the key from his sealed pouch, and cut the ligature. The prison officer then pulled the man onto the landing, as the cell was small and cramped, and made an urgent call over the radio. The incident log shows that a ‘code 1 in D wing’ was made at 10.20 pm. (Code1 is an emergency call for assistance and indicates a life-threatening situation, such as a hanging, in which the person concerned is unresponsive.) The healthcare assistant determined that the man was not breathing and found a faint pulse. He then started cardiopulmonary resuscitation (CPR), joined by the prison officer after he had made the emergency call.

73. Shortly afterwards, a temporary senior officer arrived and, having assessed the situation, went to the up to healthcare office which was within site of the man. From there, he telephoned the communications room to request an ambulance. The temporary senior officer was the Orderly Officer (also known as Oscar 1), meaning that he was in charge of the prison during the night. He then took over from the prison officer who was doing chest compressions. Around five minutes later, the nurse in charge and emergency response nurse arrived back and took over CPR. Staff did not attempt to use the emergency resuscitation equipment which was in a locked cupboard a few feet away from where they were working on the man.

74. At 10.28pm, an ambulance arrived at the prison. By coincidence, one had been passing when the call was made to the emergency services. Unusually, the gate was staffed as workmen were coming in and out of the prison. This allowed the ambulance and doctors to be swiftly processed through the gate and into the prison. Another paramedic arrived at 10.32 pm. The assistant to the Orderly Officer, met the ambulance at the main gate and escorted the paramedics to D wing, where they took over CPR.

75. Another ambulance and a doctor from Kings College Hospital attended at 10.40 pm. The doctor opened the man's chest to apply direct treatment to the heart and the man was then taken to hospital by ambulance. Two prison staff accompanied him. The officer escort was later reduced to one and this remained the case up to the man's death. There was no hot-debrief following the man being taken to hospital and it would seem that no debrief involving all staff members took place.

76. The man's next of kin as recorded on the Local Inmate Data System (LIDS), a prison-based computer system for recording prisoners' details, were his parents. An address but no telephone number was provided. The duty governor, who had been called to the prison at around 10.30pm by temporary senior officer, tried to get a telephone number for the man's next of kin through directory enquiries but found that their number was ex-directory. He therefore asked the police to visit the man's parents to tell them what had happened. In interview, the duty governor did not recall giving the police a direct number for the prison so that the family could contact anyone. The man's parents visited him at King's College Hospital at around 2.00 am on 8 March.

77. On 13 March, the man's family wrote to the prison to complain that no representative had contacted them to explain what had happened to the man on the evening of 7 March. By chance, they had discovered the burn injuries on the man's leg after a hospital blanket had slipped off and they had caught sight of them. In response, Brixton's chaplain, contacted the family and in the company of the duty governor visited the family at the hospital.

78. The man regained consciousness and was moved from intensive care to a ward. In early April, he was shown to be making progress. However, the man's condition deteriorated and he died on 28 April 2006. Staff from the hospital contacted the family to tell them of the man's death.

79. The chaplain later made contact with the man's family, and he and the Governor, visited the family a few days after the man's death. The man's family said that they had been told that the prison would pay for the full cost of the man's funeral. The prison later denied this and the family delayed the funeral until the matter was resolved. Eventually, the Governor agreed to pay the funeral expenses in full.

ISSUES CONSIDERED

Supervision

80. The man had an extensive psychiatric history. When he arrived at Brixton, he was very unwell and his behaviour clearly disturbed. Over the following five months, he was intermittently stable. The clinical reviewer wrote that lack of compliance with his medication led to repeated relapses in the man's mental state.

81. The clinical reviewer also highlighted the context within which care was being given to the man:

> "The hospital wing of Brixton Prison, D Wing, is not a hospital. It is a run-down building, overcrowded, noisy and with limited facilities. D-Wing was, at the time of these events, holding large numbers of very mentally disturbed prisoners who would undoubtedly have been in-patients in psychiatric hospitals, had they not been in prison. The staffing levels in psychiatric hospital units would have been significantly higher than was possible in HMP Brixton."

82. As noted earlier, HM Chief Inspector of Prisons, Ms Anne Owers, who undertook an unannounced inspection of Brixton just days before the man hanged himself found D wing to be seriously inadequate.

83. At 6.35 pm on 7 March, the man set fire to his right leg after stuffing his trousers with newspapers. A F2052SH suicide/self-harm monitoring form was opened and the man was placed on intermittent supervision (IS) to be observed six times an hour. The other option for staff was to place the man on constant supervision (CS). At the night shift handover, staff were told to place the man on CS should his behaviour worsen.

84. After any act of self-harm, a prisoner must become subject to suicide/self-harm monitoring. The level of supervision is always a matter of judgement. Brixton's Suicide and Self-Harm Policy describes the different levels of observation and the type of behaviour displayed:

> Constant supervision:
>
> - Actively suicidal, especially if no close relationships established with others
> - Unpredictable psychotic states
> - Recent direct self-harm with apparent suicidal intent
>
> Intermittent supervision:
>
> - Not considered actively suicidal at present but still a high risk of suicide
> - Recent self-harm with some suicidal intent

My investigators obtained records regarding the number of suicide/self-harm watches in D wing. In January 2006, there were 18 occasions of constant supervision (each occasion = 24 hours x 1 prisoner) and 103 of intermittent supervision. In February, there were four and 123 respectively, and for March, 12 and 170 respectively. This would suggest that staff will place prisoners on constant supervision if they perceive them to warrant this level of observation.

85. The clinical reviewer takes the view that:

> "… given the evidence of instability in the man's mental state over the previous few days, the clear concern of Charge Nurse in opening the F2052SH, and the episode of setting fire to himself, I think that the decision to opt for IS was incorrect."

He continues:

> "...although a number of witnesses have commented on how calm, polite and communicative the man was, there was evidence of further worrying signs, such as the man pressing his emergency bell on three occasions between 9.21 pm and 9.36 pm. At 9.00pm, shortly after coming on duty, the prison officer noted in the F2052SH that the man was requesting further sedative medication. Given the overall situation, a decision might have been made to change the status of observation from IS to CS."

86. On balance, I am not myself minded to be critical of judgements made by staff. Staff made a decision based on their experience, and their knowledge of the man. After the fire, different members of staff spoke with the man and the healthcare officer spent a considerable length of time with him. They were all of the opinion that the man was apologetic and lucid. The man did ring his bell on a number of occasions, but this in itself was not unusual behaviour for him.

87. However, I do not believe that a prisoner who has been deemed to be at risk of suicide or self-harm should have been located in a gated cell unless he was subject to constant observation. A cell closed by a gate provides a greatly increased number of potential ligature points. In trying to ascertain why staff appeared not to have considered the danger of placing an at risk prisoner in a gated cell, a confused picture has emerged.

Use of gated cell

88. Cell D1-01, and its neighbouring cell, D1-02, both had dual use. This allowed them to be used as an ordinary cell and as a gated one. By locking back the door against the internal cell wall, the external gate could be locked and used as both a barrier and to observe the occupant. The cell door to D1-01 was very difficult to open, requiring significant force.

89. It is a requirement that all cells are checked on a daily basis (these are known as Accommodation & Fabric Checks), and any problems reported to the local contractor to be fixed. On D wing, records show that any problems were either

recorded in a ‘small repairs book’ or on the daily briefing sheet. It is not known why there were two methods of recording and whether they worked independently of each other. However, both show that the problem with the door of cell D1-01 was recorded.

90. The daily recording sheets show that on 5, 6 and 7 March, the problem was passed onto Mowlem, the local civilian contractor responsible for repairs. The ‘small repairs book’ indicates that D1-01’s door had been problematic for a considerable time. It is noted on 30 June 2005, 7 July, 14 July, 26 August, 27 October and then again on 7 Feb 2006. The record indicates that each time the problem of ‘D1-01 cell door’ was noted an entry that ‘works’ had been informed would follow.

91. Records provided by Mowlem (since renamed Carillon) show that on 27 October 2005 a docket was raised and details given as ‘damaged lock cell door stop faulty’. The docket shows that someone attended on 27 October and wrote ’done’ on the docket. Another docket was raised on 3 January 2006, and the repair was recorded as ‘unspecified cell door stiff, may need greasing’. A worker attended on 4 January and had written ’completed’ on the docket. On 7 February, another docket marked urgent was raised. A locksmith attended the same day and ‘found the lock and gate hinges to be stiff but operational’.

92. The ‘occupancy history’ record of cell D1-01 was reviewed by my investigators. The record starts on 31 March 2005 with a prisoner being placed in the cell. There is no corresponding departure date but other records show that he left the prison on 7 April 2005. The cell then appears to have been empty until 26 October. After that, it was in almost constant use until March 2006. The man was located in D1-01 from 19-25 November and 1-22 December.

93. In interview Head of Healthcare, said:

> ”… there were problems with the door on D1-01 and that had been reported over quite a lengthy period, and it periodically worked and periodically didn’t. Sometimes the Works had been contacted and somebody has come over and put oil on the hinge or lifted it slightly because it was sticking, you couldn’t use it safely. So sometimes it was used with the door open but a gate only.”

I take the head of healthcare’s remarks as confirmation that the cell was being used as a normal cell but with the door open and the gate used as a barrier.

94. The impression I gain is of a problematic cell door which the repair team felt was operational, but the staff in D wing considered to be defective. Under such circumstances, I would have expected a decision to have been made about whether to take D1-01 out of commission until the door was fixed. Staff could have continued to use it as and when a gated cell was required. However, this did not happen and cell D1-01 continued to be used as an ordinary cell but with a gate.

95. The head of healthcare was asked in interview about instructions regarding the use of gated cells. He said that he was not aware of any policy about the use of gated cells. He was unable to recall having any discussions with his staff or other senior staff about the appropriateness of using gated cells other than for constant supervision. The head of healthcare said that the man had been in the cell intermittently, for a few days at a time. He said staff felt it was more beneficial to the man's health as he had an increased level of contact with other prisoners such as the cleaners, and he could interact with staff more easily than through a small hatch.

96. Prison Service Order 2700, Suicide and self-harm prevention, provides instructions and mandatory requirements and came into effect in January 2003. One of the requirements of PSO 2700 is that each establishment must have its own local suicide and self-harm prevention strategy. The strategy must include reference to a number of conditions including 'when to use the establishment's specialist designations eg safer cells'. Brixton's Suicide and Self-Harm Prevention Local Operating Practice (effective from November 2005) makes no reference to safer cells, constant supervision, or the use of gated cells except to draw the reader's attention to PSO 2700 Chapter Four for 'segregation and accommodation of at risk prisoners'. Brixton's Suicide and Self-Harm Prevention Policy does not make reference to the use of 'safer cells'.

97. I am concerned that no action was taken regarding the continued use of cell D1-01, a gated cell being used as an ordinary cell. Chapter 4 of PSO 2700, Managing prisoners identified at-risk to self, discusses the different types of accommodation for at-risk prisoners. The reader is advised to refer to safer cell protocols in section 4 of the guidance document accompanying the PSO. According to the protocol, D1-01 would be classified as a dual use gated cell. (Dual use is achieved by detailing a standard cell door and gate to operate separately.) The protocol states that:

> '… gated cells are used where a prisoner requires constant observation. They enable a severely distressed/at risk prisoner to receive individual support designed to reduce their heightened emotions. A person should remain in a gated cell for the shortest time possible.'

98. The protocol also says, 'gated cells should not be used to house prisoners without constant observation when the gate is in place'. This is described as 'prohibited usage'. Clearly, D1-01 was being used contrary to the protocol.

99. The man was moved from his cell after he pulled the toilet off the wall on 6 March. The healthcare assistant, who was the first to arrive when the man set fire to himself the next day, recalled that the gate was in place and that he saw the smoke and flames through it. The second nurse, who got the fire extinguisher, says the door was in place. The self-harm/suicide form (F213SH), which is used to record any acts of self-harm, described the man as being in a gated cell. On balance, the evidence would suggest that when the man was placed in cell D1-01 the gate was in use.

100. My investigator and clinical reviewer discussed with the head of healthcare whether it could have been possible that the man was placed back in to cell D1-01 because there was no other available space on D wing. The head of healthcare produced a written breakdown of the occupancy levels for D wing which suggests that this was not the case.

2 March Unlock 30 (2 cell risk, 2 repair, 1 decorate) D1-01 not occupied
3 March Unlock 30 (2 cell risk, 2 repair, 1 decorate) D1-01 not occupied
4 March Unlock 30 (2 cell risk, 3 repair) D1-01 not occupied
5 March Unlock 30 (1 cell risk, 4 repair) D1-01 not occupied
6 March Unlock 30 (1 cell risk, 3 repair, 1 decorate) D1-01 occupied by the man

101. The balance of evidence suggests that D1-01 had been used on many occasions as a gated cell, including the man's previous occupancy. Indeed in the man's case, at least, being in cell D1-01 with the gate in place was seen as a positive thing. The lack of other cells does not seem to have been a factor in the accounts given by all staff. My investigators were left with the impression that staff had got used to using D1-01, and on this occasion did not consider the implications of the gate in terms of providing ligature points.

The Governor should urgently review the local Suicide and Self-Harm policy to reflect the use of gated cells, including their prohibited use.

Should the man have had a lighter?

102. In interview, the Healthcare Manger, the head of healthcare, said that all prisoners are risk assessed with regard to in-cell possessions. The man was a smoker who had in his possession a lighter which he subsequently used to set fire to himself. However, staff had not deemed the man to be at risk with a lighter and, except with the certain vision of hindsight, I have found no evidence to indicate that this assessment was unreasonable at the time it was made.

The transfer from HMP Pentonville

103. Due to the temporary closure of the healthcare department at HMP Pentonville, other London prisons were asked to co-operate with any transfers. The transfer of prisoners between prisons is routine and is often done in circumstances beyond the control of staff, for example, following a court appearance. However, in the case of a mentally ill prisoner this should not occur unless there has been a discussion between clinical teams from both the departing and the receiving prison. In the man's case, this does not seem to have taken place in spite of the fact that the move was planned. When he arrived, staff at Brixton immediately felt that in the light of his poor health he should never have been transferred.

104. The clinical reviewer viewed the transfer of the man as highly inappropriate given how unwell he was at that stage. As the man had been in Pentonville since May 2005, a sudden and unplanned transfer could have resulted in a further deterioration in his mental state. However, given that the healthcare

centre at Pentonville was closing, a transfer had to take place. In the circumstances, I make no criticism of the transfer decision itself but an informed discussion between the responsible psychiatrists at Pentonville and Brixton should have taken place prior to it taking place. I endorse the clinical reviewer's following recommendation:

The transfer of psychiatrically ill prisoners between prisons should only take place after a discussion between and agreement of the psychiatrists responsible for the care of the prisoner at both ends of the transfer.

Actions after the man was taken to hospital

105. Given that the man was alive when he left Brixton, there appears to have been some confusion over what should happen next. For a death in custody, there are contingency plans which are co-ordinated by the duty governor, assisted by the Orderly Officer. But although at that time it was not a death, the events of 7 March constituted a very serious incident involving D wing staff who had witnessed a traumatic medical procedure. Some members of staff said that no manager had spoken to them on the night, or thereafter, to discuss either their involvement or how they were feeling. The Staff Care and Welfare team appear not to have been made aware of the events. There was no debrief on the night or at a later date, although one member of staff was allowed to go home as he was very traumatised. Medical staff were not asked to provide statements of their involvement. I think this was all very unfortunate and that, when such a serious incident occurs, the contingency plans for a death in custody provide a good guide to the actions to be taken.

The Governor should develop a process to ensure appropriate records are kept and support offered to staff following a serious act of self-harm.

Family contact

106. The duty governor was responsible for co-ordinating the contingency plans following the man's departure to hospital. Given the serious nature of the man's injuries, the family had to be contacted. The duty governor said that he was unable to find a telephone number on the LIDS system. My investigators found a number in the man's paper records so it is not clear why this information had not been copied to the database. However, in the absence of a phone number, and given the distance from the prison to the family's home address, the duty governor asked the police to make contact with the man's parents to break the news. The man's parents said that when the police came to speak to them, they were unable to provide even the basic facts about what had happened to their son.

107. The duty governor did not recall giving the police a number to call at the prison or a named person as a contact. I am quite clear that this information should have been given and passed onto the family. In interview, the duty governor said that he had wanted to go and visit the family the next day, but the Governor at the time had said he should not go. The duty governor explained that there

was some confusion at the prison about whether or not they needed to appoint a Family Liaison Officer (FLO) as the prisoner had not died.

108. The man's family wrote to Brixton some days later to complain that they had not seen a representative from the prison. Following this, on 16 March, the duty governor and the chaplain went to meet the family at the hospital. The chaplain then maintained some contact with the man's family until the man died.

A family liaison officer should be identified when a serious incident of self-harm occurs.

109. The family said that they had been led to believe by the chaplain that there would not be any restrictions on funeral expenses. The guidance in Chapter 4 of PSO 2700, Follow up to Deaths in Custody, says that the prison "must pay reasonable funeral expenses or, if the family want particularly expensive arrangements, offer a contribution". After an exchange of letters, the prison agreed to pay the cost of the funeral in full, which was double the amount that Governors have the discretion to pay. The dispute over the funeral payments led to postponement of the funeral and the family blame the prison for this.

The Governor should issue guidance outlining the information to be given to the family and the conduct of the family liaison officer.

110. Following a meeting with the man's sisters and their solicitors, my investigator wrote to the current Governor of Brixton drawing his attention to the family's concerns about the quality of family liaison. The current Governor acted promptly and allocated another FLO to the man's family as the chaplain who had been acting as the FLO had retired. Concerns over missing property were then resolved and items returned to the family, along with some private cash that was also found. I am grateful to the current Governor for personally attending to these matters and commend his actions.

Staffing levels on D wing at night

111. D wing Operating Procedures set out the requirements for all aspects of work in the healthcare unit, including the optimum staffing levels. At night, they stipulate that there should be three nurses, one discipline staff and one healthcare assistant. After the departure of the two nurses from D wing on 7 March, there were no qualified nurses in the in-patient healthcare unit. The workload for the two remaining members of staff was very high given the number of prisoners presenting with acute needs. My investigators were unable to find out why only four staff had been working nights when five was considered to be the appropriate level.

The Governor and Head of Healthcare should review the allocation of night staff to D wing and, if found to be persistently operating below the optimum level, increase the number of qualified staff placed on the wing.

The resuscitation of the man

112. The clinical reviewer looked in detail at the resuscitation of the man and spoke with a healthcare officer who is responsible for CPR training in Brixton. The emergency bag for D wing was kept in a locked cupboard just opposite D1-01. However, at no point during the resuscitation did staff bring it out. This was despite the fact that, once the nurses arrived back at D wing, at least five members of staff were in attendance. The clinical reviewer judged that one of the staff should have obtained the emergency bag from the cupboard which was only a few feet away from them.

113. In her inspection report, HM Chief Inspector, Ms Anne Owers, commented '…of particular concern was the fact that the resuscitation equipment for the in-patient unit was kept in a locked cupboard and did not appear to be easily accessible.' Ms Owers recommended, 'all staff should know the location of resuscitation equipment, which should be easily accessible at all times.'

114. The clinical review makes three recommendations about CPR.

The Clinical Review

- The clinical review looked in great detail from a clinical perspective at the adequacy of the healthcare that the man received at Brixton, and after he was found hanging. The clinical reviewer raised a number of concerns, listed below: The appropriateness of having such a seriously ill inmate on the Hospital Wing of HMP Brixton, rather than in a secure unit psychiatric hospital.
- The effectiveness and appropriateness of the system for ensuring transfer of seriously mental health patients from HMP Brixton to a psychiatric hospital.
- The lack of a mechanism to resolve a clinical dispute between the psychiatrists at HMP Brixton and the psychiatrists of the secure psychiatric unit about appropriate treatment.
- The failure of the psychiatrist assessing the man for a second opinion, to give an opinion on the specific reason for the referral.
- Issues around medication for the man, especially the appropriateness of the dose reduction of sedative medication on 7 March 2006, and the lack of adequate medicines management support from the Pharmacy Dept.
- The lack of a system for effective communication between the psychiatrists providing psychiatric care on D-Wing in normal working hours, and the GPs providing medical cover in the evenings, nights and weekends.
- The appropriateness of having no psychiatric cover for HMP Brixton outside normal working hours.
- Lack of adherence of prison staff to agreed protocols in managing the resuscitation attempts on the man in the evening of 7 March 2006.
- The effectiveness of the resuscitation attempt on the man in the evening of 7 March 2006, and how this could have been improved.
- Training issues for all prison staff in managing CPR (cardio-pulmonary resuscitation).

- The lack of a significant event or critical incident analysis following the incidents on 7 March 2006.

In addition to the issues already discussed, the clinical reviewer made a number of additional recommendations which I fully endorse.

RECOMMENDATIONS

1. the Governor should urgently review the local Suicide and Self-Harm policy to reflect the use of gated cells, including their prohibited use.

Accepted. The policy will be reviewed in its entirety, by the membership of the safer custody meeting, which includes managers, staff, Listeners and Samaritans. The use of gated cells has already been reviewed and a notice issued, but this will now be incorporated into the overall policy.

2. The transfer of psychiatrically ill prisoners between prisons should only take place after a discussion between, and agreement, of the psychiatrists responsible for the care of the prisoner at both ends of the transfer.

Accepted. This should already happen. A meeting is being set up by London area office to establish a London wide protocol. There are obviously occasional un-planned transfers due to the population pressures and movements from court, police cells etc.

3. The Governor should develop a process to ensure appropriate records are kept and support offered to staff following a serious act of self-harm.

Accepted. Locally HR are developing a process, critical incident de-briefs and Staff Care and Welfare offered.

4. A family liaison officer should be identified when a serious incident of self-harm occurs.

Partially accepted. HMP Brixton recognise this is good practice, but the creation of the FLO role was really for use in those instances where there had been a death in custody. Use of FLOs in cases of serious self harm may not always be practicable. There are now 3 trained FLOs at HMP Brixton.

5. The Governor should issue guidance outlining the information to be given to the family and the conduct of the family liaison officer.

Accepted**.** The intention is to have trained FLOs used in such instances.. Nonetheless guidance and information will be provided for all, taken from the training manual/package. Extensive guidance for FLOs is available as an annex to PSO 2710, Follow up to deaths in custody.

6. The Governor and Head of Healthcare should review the allocation of night staff to D wing and, if found to be persistently operating below the optimum level, increase the number of qualified staff placed on the wing.

Accepted**.** Completed. Now re-profiled. The staffing contingent for night duty on D-wing is 2xE grade nurse, a Healthcare Assistant and 1x discipline officer. The two trained members of staff have clinical responsibility not only for D-wing but for the whole of the prison. There may be times when responding to a code 1 emergency

that both trained members of staff would go to the scene thereby leaving the Healthcare Assistant and the discipline officer in a patrol state within that unit. This discipline officer would always be a regular member of the healthcare team and would continually patrol that unit carrying out intermittent supervision (every 10 mins) which is documented.

Additional recommendations for the Clinical Review

7. The process of referring a severely mentally ill prisoner from a prison such as HMP Brixton to a secure unit psychiatric hospital should be reviewed and made more efficient. When a referral is made, the assessment should take place very quickly. If the transfer to a psychiatric hospital is agreed, that transfer should then take place as quickly as possible.

Partially accepted. It is difficult to get prisoner patients to take priority when they are already in a custodial setting. This is a national issue and cannot be tackled by Brixton in isolation. Work is presently being done within NHS London to move it forward, via negotiations with the various London PCT's and Mental Health NHS Trusts.

Nationally pilots are currently under way to establish a transfer waiting time standard between prisons and Mental Health units. A report on the waiting time standard is due by end December 2007.

8. If a referral of an inmate for hospital care is refused, the psychiatrist refusing the referral should discuss the decision with the referring psychiatrist, if possible by meeting together at the time the decision is made. The psychiatrist refusing the referral should participate in creating a workable management plan for the inmate who will now continue to be cared for in prison. This is particularly important given that currently there is no clear process of appeal to a third party if the two psychiatrists disagree as to the best plan. In these circumstances there should be agreed procedures as to how to take things forward, probably including the active participation of the prison governor and also of the local primary care trust, in this case Lambeth PCT. It is not acceptable to leave the responsible psychiatrist at HMP Brixton to manage a patient, if he feels that it is clinically inappropriate to have this patient on his unit.

Accepted. HMP Brixton have a working system for engaging external psychiatrists through CPA (Care Programme Approach) meetings. External attendance is variable, and our experience of engaging local services in the care and treatment of patients they have refused for admission suggests that full implementation of this will present considerable difficulties. We agree, however, with the underlying principle.

9. If there is still disagreement about the appropriate place of care for a mentally ill prisoner, then there should be a robust system for rapidly resolving the disagreement, with a decision binding on both psychiatrists.

Accepted. There is presently no available appeal mechanism. One is currently being recommended for London, along the lines of the Special Hospital Admission Panel,

and we hope that NHS London will be able to take it forward through the Strategic Health Authority in due course.

Nationally Strategic Health Authorities currently have a role in mediating in such cases.

10. Lambeth PCT should move towards organising contracts for the provision of psychiatric care at HMP Brixton that will provide for psychiatric care outside normal working hours, and at weekends and bank holidays. This is particularly important as it is currently not possible to admit an acutely mentally ill inmate to an NHS psychiatric unit as an emergency.

Accepted. This clearly has substantial resource implications, but has been included as a requirement in the service specifications for the new provider when Brixton's healthcare is outsourced. We need to balance this against making the prison too much of an "acceptable" place to send the floridly psychotic and incapacitated, which could ultimately be to the detriment of mentally disordered offenders at HMP Brixton.

There is a need for local communication, facilitated by the PCT, to ensure emergency transfer takes place appropriately and to work towards making speedier hospital transfers.

11. A process of significant event analysis (SEA) should be introduced for all major incidents of self harm or significant suicide attempts. The SEA process should also be used for all other major medical incidents. The SEA should help to identify the learning needs of individual members of staff, as well as the need to develop and refine systems and protocols of care.

Accepted.

12. A system should be developed to pass important clinical information between the psychiatrists and the GPs working at HMP Brixton in relation to prisoners who are severely ill, or are thought to be at risk of relapse or self harm. Plans for the care of such 'at risk' patients should be passed on to the GPs, as well as advice on what to do in an emergency.

Accepted. This system already exists. Clinical information is passed regarding D wing patients via the tracking meeting, which has multi-disciplinary attendance and takes place every Monday at 1200, and via shared medical records. The volume of mental disorder at Brixton makes daily meetings impossible.

13. The senior psychiatrists in the prison (at consultant or specialist registrar level) need to develop systems to ensure the accuracy and appropriateness of prescribing of their junior members of staff. This will also help in identifying training needs of the junior staff.

Accepted. This system is already in place. Supervision of junior staff takes place at ward rounds, and through individual supervision sessions which happen weekly. This is in accordance with the rules and regulations of the Royal College of Psychiatrists.

14. In addition, arrangements should be made to ensure that a pharmacist is present at the regular weekly ward rounds on D-Wing, to ensure full and effective medicines management support, and to highlight *problems and offer advice to clinicians in relation to their prescribing.*

Accepted. A Pharmacist will be present at the regular weekly ward rounds (currently held on D wing on Tuesdays at 2pm). A Pharmacist will also attend D wing every week day morning to review all prescriptions.

15. Protocols for cardiopulmonary resuscitation (CPR) should be developed at HMP Brixton. These protocols must make it clear who is responsible for bringing the Ambu Bag equipment to the site of any Code 1 emergency.

Accepted. Full protocol to be developed in line with the full review of the suicide prevention policy.

16. The use of airways, such as the Guedel airways in the Ambu Bag, when carrying out the chest inflations of CPR should be encouraged. This may require more training of staff in order to improve the knowledge and confidence of the staff in the use of airways.

Accepted**.** All training delivered encourages the use of the airways and is refreshed annually.

17. Training procedures for prison staff in CPR need to be looked at again particularly in terms of the use of artificial airways. Other areas of training need in CPR should be re-examined. The frequency of refresher training for staff may need to be reassessed, to ensure that all staff can administer CPR to the highest possible standard.

Partially accepted. As above, refresher training for all Healthcare staff is delivered annually, and is up to date. To include all prison staff would not be viable. We would certainly not expect prison officer grades to carry out invasive techniques such as the insertion of oropharyngeal airways.

18. The training needs of the GPs working at HMP Brixton in terms of their work with severely mentally ill prisoners should be identified and met.

Accepted. The patient client group at HMP Brixton is a complex group presenting a range of challenging needs. Working within the custodial environment also presents new challenges. The training requirements of GP's will be reviewed by Lambeth PCT.