# Investigation into the circumstances surrounding the death of a man at HMP Brixton on 18 April 2007

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

**September 2008**

This is the report of an investigation into the circumstances of the death of a man at HMP Brixton. This man was a remand prisoner who was found hanging in his cell on B-wing on 18 April 2007. He was 63 years of age and had been on remand for just over five months.

I extend my sincere condolences to the man's family and friends for their loss.

The investigation was carried out by one of my colleagues. Lambeth Primary Care Trust agreed to carry out a review of the man's clinical care and treatment while at Brixton. That review was delayed for a considerable period of time but was eventually received at this office on 30 January 2008.

I would like to thank the Governor of Brixton, and his staff for their help.

In January 2007, the man took an overdose of his in-possession medication. For a period afterwards he was made subject to special monitoring in case he harmed himself again. On two subsequent occasions the special monitoring procedure was started. It was closed both times within 24 hours.

After his death, several torn up letters were found in the man's cell. All were addressed to his daughter and all indicated that the man was considering ending his life.

I have made three recommendations. One concerns referrals to the prison's psychiatric outreach team and one the operational procedure for dealing with prisoners deemed at risk of suicide or self-harm. The third recommendation relates to the clinical review.

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

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## SUMMARY

The man was 63 year's of age. He had been on remand since 9 November 2006 following certain allegations made by his wife to the police.

During his first reception health screening interview the man revealed that he had recently been treated in hospital for an overdose. He said, however, that he took the overdose not in order to harm himself but instead to try to win sympathy from his wife. The man denied having any present thoughts of self-harm.

The man was located onto G-wing, but within a day he asked for a transfer to another wing as he feared other prisoners who seemed to be aware of the allegations against him. As a result, the man was moved to B-wing which at the time mainly held Brixton's foreign national prisoners as well as a number of vulnerable prisoners.

Nothing of any particular note occurred until 11 January 2007. The man complained that he was not feeling well and when a nurse was asked to examine him he told her that he had taken an overdose of his in-possession medication. The man was taken to outside hospital and an ACCT[1] form was opened. On 12 January, the man was visited in hospital by an ACCT assessor for an assessment interview (the ACCT process includes an assessment by a trained assessor within 24 hours of the form being opened). The man spoke at length and said that he had lost everything from his life. However, he also said that he would never try anything like that again. The ACCT form was kept open at that stage.

The man remained in hospital until 20 January when he returned to Brixton. On 22 January, the man was seen for an ACCT review when staff decided that the form should be kept open. Two days later the man approached staff asking for the ACCT form to be closed. A further ACCT review was held and the form was closed.

By this time the man was in C-wing but, as had happened when in G-wing, he began to sense some hostility from other prisoners. The man was moved back to B-wing.

On 7 February, the man saw one of Brixton's GPs to say that he was feeling depressed and was having trouble sleeping. The man denied any thoughts of suicide but because of his recent overdose the doctor opened a new ACCT form. The next day the man was seen by an ACCT assessor for the standard 24 hour review. The man said that all he had done was to ask the doctor for some anti-depressants to help him sleep and he did not understand why the form was opened. The man denied having any suicidal thoughts. The man gave the assessor no cause for concern. After discussion with his manager, the assessor closed the ACCT form.

On 3 April, the man telephoned his solicitor to ask about the possibility of obtaining bail. She told him there was little point in applying as his circumstances were

[1] ACCT (Assessment, Care in Custody and Teamwork) is the process for managing and supporting prisoners who are judged at risk of self-harm or suicide. ACCT has replaced the previous process, the F2052SH procedure.

unchanged from when he had been originally refused bail (in November 2006). The solicitor thought that the man seemed dejected at this news so she telephoned Brixton's healthcare unit. The member of staff in healthcare who took the solicitor's call passed the message to B-wing.

In B-wing, an ACCT form was opened. The officer who did so noted in the form that the man had been refused bail and this might lead to self-harm. A senior officer in B-wing went to speak to the man because he had been on open ACCT forms on previous occasions. The man told the senior officer that he had not been to court and had not been refused bail. It seems the computer system might have been checked and this confirmed that the man had not gone out to court in the last few days.

The next day the man was seen by an ACCT assessor. The man told her that he had not been to court, had not been refused bail, and was therefore confused why the form had been opened. He added that his bail hearing was going to be in June and that he was feeling fine. The assessor noted that the man was stable and happy and she and the senior officer agreed to close the ACCT form.

Nothing else of significance occurred until 18 April 2007. During morning roll call that day the man was found hanging in his cell. When staff entered the cell they found from the condition of his body that he must have been dead for some time.

## THE INVESTIGATION PROCESS

The investigation was opened on 20 April 2007 when my colleague visited Brixton and met a number of prison staff, including the Governor and a representative from the Prison Officers' Association. My investigator informed all those he met of the nature and scope of the investigation. Notices were issued both to staff and prisoners notifying them of the investigation. On a subsequent visit my investigator also met the chair of the Independent Monitoring Board (IMB).

Nineteen members of staff were interviewed. The police gave my investigator copies of statements they had taken from several prisoners, including one who was on reasonably friendly terms with the man. My investigator wrote to this prisoner who had by then been released, but he did not respond. No prisoners came forward to give evidence directly in response to the published notices.

The local Primary Care Trust (PCT) agreed to carry out a review of the man's clinical care and treatment while at Brixton. After a considerable delay, the PCT commissioned a private company to carry out the review on its behalf (the company conducts work for the Department of Health as well as other bodies). The review into the man's death was one of five reviews into deaths at Brixton commissioned in the same way, and at the same time, from this company. No specific recommendations were made in the man's review, but a number of generic recommendations were made based upon the findings from all five reviews. Both the man's clinical review and the generic recommendations are appended to this report.

One of my Family Liaison Officers contacted the man's next-of-kin, his daughter. My investigator and family liaison officer visited the man's daughter and her husband. The man's daughter questioned the closure of the ACCT forms that had been opened for her father. She said the last one had been closed following some miscommunication within the prison.

The man's daughter mentioned a complaint her father had made about officers kicking him in the leg. The man's daughter said she raised the matter with a governor who investigated the allegation, but staff denied any wrong doing.

The man's daughter mentioned letters her father had written indicating that he was thinking of suicide. These letters were found ripped up in the bin in his cell following his death. One was dated 31 March. The man's daughter questioned why her father's cell had not been checked given that he had previously taken an overdose.

The man's daughter said that she usually visited her father on Saturdays, and on Saturday 14 April he seemed his usual self. The man's daughter also said her father telephoned her several times the evening before he died, but it was not unusual for him to telephone several times during a single day. He told her that he loved her and that he was looking forward to her visit on the following Saturday. The man's daughter told my staff that there was nothing out of the ordinary in her father's tone and conversation.

**HMP BRIXTON**

Brixton first opened in 1819 and in its time has been both a prison for women and a military prison. Brixton's primary role now is as a local prison holding remand and trial prisoners committed to the local magistrates' courts, as well as the Inner London and Southwark Crown Courts. Brixton also holds prisoners committed to Bow Street Magistrates' Court which is responsible for extraditions to Ireland.

Brixton comprises five main residential units or wings. The man spent time in four of these wings. At the time, G-wing was the first night, remand and detoxification wing. D-wing was used to house prisoners with mental health needs and those who required medical observation. C-wing was used to house prisoners engaged in drug intervention programmes, and B-wing mainly held foreign national prisoners plus a small number of vulnerable prisoners[1].

The most recent inspection of Brixton by Her Majesty's Chief Inspector of Prisons an unannounced inspection in February and March 2006. The Chief Inspector findings included:

> "Vulnerable prisoners were located on the third landing on B-wing. A published regime had been introduced and prisoners were allowed to attend all prison activities. Association, access to telephones and showers were received daily."
>
> "Ten prisoners were over 60 … They were located in residential units throughout the prison. There were no systematic arrangements to identify and deal with their specific needs … Some older prisoners with mobility difficulties relied on other prisoners to collect their meals and help them into showers …"

[1] Brixton has recently reconfigured the role and function of each of its wings.

## KEY EVENTS

### *Events leading up to the man's death*

On 9 November 2006, the man appeared at Tower Bridge Magistrates' Court where he was charged with several offences arising from accusations made by his wife. At court, the man was remanded into prison custody and was taken to HMP Brixton.

When he arrived at Brixton, the man was seen by the reception nurse for a standard first reception health screen assessment. In answer to a question about whether he had received any physical injuries in the last few days, the man said he had been treated at hospital after taking too many tablets. The reception nurse did not record if this was a deliberate or accidental overdose. In answer to a question about whether he had ever tried to harm himself, the man replied that he had not. At interview, the reception nurse told my investigator that the man said he had been having a hard time with his wife and had taken an overdose to gain her sympathy and attention. His intention had not been to actually cause himself any harm. The man also said he would not harm himself in Brixton. The man had been relaxed through the interview and the reception nurse was satisfied that his behaviour and mental health state were normal and that he was not at risk of self-harm. The reception nurse recorded on the assessment form that he did not think it appropriate to open an ACCT form (or F2052SH).

The man was initially located in G-wing, but within a day he asked for protection under Prison Rule 45 as he was concerned for his safety. The man's records indicate that other prisoners were aware of the allegations that his wife had made against him. As a result, the man was moved to B-wing where vulnerable prisoners were housed.

A prison officer spoke to the man on 13 November after a message was received suggesting that he might be at risk of self-harm. After they spoke, the officer recorded that the man said that he was feeling a little bit down but that he had no intention of harming himself.

On 20 November, the man saw a prison nurse and complained about asthma-related tightness in his chest. The nurse's note of the consultation included the man saying that he had lately been under considerable stress. He was low in mood but had no thoughts of self-harm.

The man was due to go to court on 11 January 2007 for a remand hearing. At 4.00am that morning the night nurse was called to B-wing when the man told the night officer that he had taken an overdose. The nurse examined the man and found his clinical observations of blood pressure, pulse and respirations were all within the normal range. The night nurse recorded that the man appeared comfortable, alert and orientated in time and place. The night nurse told the man that he would be examined again before going to court. She also advised wing staff to contact healthcare again if there were any changes in the man's condition.

At about 7.30am on 11 January the man was in reception waiting to go out to court. A nurse was called to examine him as he was complaining that he was not feeling

well. At interview, the nurse said that the man appeared weak, dehydrated and depressed. The man told the nurse that he had taken some sleeping pills as well as 200 co-dydramol tablets (co-dydramol is a painkiller that had been issued to the man as in-possession medication). The nurse examined the man and told the prison gate to send the doctor to her as soon as he arrived in the prison which would normally be at about 7.45am. When the doctor arrived he decided to send the man to outside hospital where he remained for over a week.

In response to the man's actions, an ACCT form was opened the same day. In the afternoon of 11 January the duty governor visited the man. The reason for her visit was because the man's daughter had reported to Brixton a telephone conversation with her father alleging inappropriate behaviour by officers. There were two complaints. One was that an officer had assaulted the man in his cell. The other complaint was that at hospital the man had been handcuffed to his bed. The duty governor told my investigator that she spent about an hour with the man. A lot of their conversation was about the man's wife and the allegations she had made against him. The duty governor said that the man reported being depressed, saying that he did not want to live.

When the duty governor asked the man about his complaints he told her that he had not been assaulted by an officer. Instead, his complaint was that officers could have been more attentive. He said that he was due to go for a remand hearing in court that morning. As he was being escorted to reception at around 7.00am he told the officer that he was not feeling very well. He said that the officer was not interested in what he said. The duty governor told the man that his complaint would be investigated. On the other matter, the man said that he had not been handcuffed to his bed but was complaining that he had been handcuffed to an officer. The duty governor explained to the man the rules concerning handcuffing. These are that prisoners in hospital are handcuffed to an officer and the cuffs are usually unlocked only to allow clinical treatment to be given. The man accepted this explanation.

When the duty governor returned to Brixton she wrote a report about the man's complaint that she passed up the management chain for the Governing Governor or Deputy Governor to investigate. The next morning the duty governor spoke to the suicide prevention co-ordinator, to ask him to visit the man to carry out an ACCT assessment interview.

The suicide prevention co-ordinator confirmed that he visited the man on 12 January and carried out an ACCT assessment interview (the ACCT process requires that a case review be undertaken within 24 hours of the form being opened). The suicide prevention co-ordinator told my investigator that he spent around two hours with the man. This was about twice as long as he would normally spend on an assessment interview. The suicide prevention co-ordinator said that the man spoke at great length, saying that he had lost everything from his life. At the same time, the man was not over-emotional. The suicide prevention co-ordinator made extensive notes in the man ACCT form. In answer to a question about previous acts of self-harm/suicide attempts, the man said that he had made no previous attempts. In the section of the form headed *'Current suicidal thoughts'* the suicide prevention co-ordinator recorded:

> "The man has no further plans or thoughts of self-harm … I shall never try anything like this again."

Under the section of the form headed *'Reasons for living and coping resources'* the suicide prevention co-ordinator recorded:

> "The strength and support of his daughter and first wife."

The suicide prevention co-ordinator's summary of his assessment included:

> "The man is going to be in hospital for some time … but is adamant that he will never attempt anything like it again. Never stops talking – which is a good sign …"

The suicide prevention co-ordinator concluded that the man's current likelihood of further acts of self-harm was low.

On 20 January, the man was discharged from hospital. He returned to Brixton and was located in D-wing for medical observation.

One of Brixton's doctors saw the man on 21 January and noted in his records: *"Well. No thoughts of self-harm, can return to wing when cell available."*

The man was seen by a principal officer on D -Wing and a nurse on 22 January for an ACCT review. The principal officer estimated that the review had lasted about 20 to 30 minutes. The man had said he was very depressed at the time he took an overdose but did not intend to do the same thing again. The principal officer said that the man was not happy about being in D-wing and wanted to return to ordinary location. Nor was he happy about being on an open ACCT form, possibly because of the level of observation he was under. The man was still low in mood and so the ACCT form was kept open.

The principal officer on D-Wing saw the man again on 23 January for a 'discharge from healthcare' review after the doctor had deemed him fit to move to ordinary location. The principle officer thought that this news had lifted the man's mood from how it had been the previous day. Later that day the man moved from D-wing to C-wing.

On 24 January, a senior officer agreed to the man's request for a case review of his ACCT form. This senior officer, the man and a prison officer attended the review. The senior officer and prison officer agreed to close the ACCT form and recorded the reasons for their decision:

> "The man has now accepted his marital situation and is quite keen to move on with his life. He … regrets the [previous attempt at suicide]. We have decided to close the ACCT and informed him if he feels he needs to talk he can see his landing officer, a Listener[1] or Samaritan …"

[1] Listeners are prisoners trained by the Samaritans to provide the same service as Samaritans offer in the community.

A senior officer who works on C-wing first met the man when she visited him while he was still in D-wing. She was asked by one of the governors to check that the man was comfortable about moving to C-wing as he did not fit the usual criteria for the wing (C-wing was usually for prisoners addressing drug behaviour issues). The fact that the man was on an open ACCT form was an added reason for this senior officer's visit. The man told her that he was content to move to C-wing.

On 26 January, the man reported to the senior officer from C-Wing that other prisoners on the wing had suddenly become threatening and hostile. He suspected word had got out about the nature of his charges, but he did not wish to identify the prisoners. The senior officer with a principal officer met the man to discuss the situation. A note was made that the man was now concerned about his safety on normal location. As a result he was again moved to B-wing where he had been located on a previous occasion.

The man consulted another of Brixton's doctors on 7 February. The doctor recorded that the man was depressed, had low motivation and was sleeping poorly. The doctor prescribed a dose of anti-depressants. In addition, he opened an ACCT form. He recorded his reasons for doing so as: *"Recent attempt at suicide … feels depressed, denies suicidal ideation, but in view of recent [overdose] open ACCT. Refer urgently [to psychiatric outreach team] …"* At interview the doctor said that he could not really recall the man, but he was confident that it was appropriate to open an ACCT form in view of the man's report of feeling depressed, and in particular because he had taken an overdose the previous month. The doctor said that the procedure for referring a patient to the psychiatric outreach team was to complete a handwritten referral form. Although that should normally result in the patient being assessed within 48 hours, it did not always happen. (The man was never in fact seen by the psychiatric outreach team.)

The man was seen the next day by an ACCT assessor, for an assessment interview. A second senior officer was also present. The ACCT assessor told my investigator that the man said he was fine and did not understand why the form had been opened. The ACCT assessor recorded the man saying that he had asked the doctor for anti-depressants in order to help him sleep. The man acknowledged that he had previously taken an overdose, but said he now realised that was a stupid thing to do. The man was asked whether he had any current suicidal thoughts. He replied that he had no such thoughts and that he felt fine. To help him cope he had very good support from his daughter. The ACCT assessor estimated that the meeting lasted 30 to 40 minutes and the man gave him no cause for concern. When the man left the meeting, the ACCT assessor and the senior officer discussed his case and agreed that the ACCT form should be closed.

On 3 April, the man telephoned his solicitor who told my investigator that the man rang to ask about bail. The solicitor explained that his circumstances had not changed in the time since his failed application in November 2006. As a result, there was little point in making a renewed application. The man was dejected at this news so his solicitor telephoned Brixton and spoke to a senior officer in healthcare.

The healthcare senior officer made the following entry in the man's records:

> "Phone call received from the solicitor of this man. His bail application is apparently unlikely to be unsuccessful and she feels that he may take this news very badly and could be at increased risk for a period. B-wing staff … informed of this information by myself."

A B-wing officer remembered taking a telephone call from the healthcare senior officer on 3 April. The B-wing officer opened an ACCT form recording that the man had been refused bail which might trigger him to self-harm. The B-wing officer told my investigator that his understanding of the call from the healthcare senior officer was that the man had actually been refused bail (not that he was likely to be unsuccessful with a future application). The B-wing officer went to speak to the man, who was puzzled. He said that he had not yet gone to court and could not therefore have had bail refused. The B-wing officer said that the man seemed fine, although he was possibly annoyed because he would be kept under close observation through the night.

A B-wing senior officer said that he went to speak to the man as soon as he found out that an ACCT form had been opened. He would not ordinarily go to see a prisoner straight away, but did so this time because the man had had ACCT forms opened on previous occasions. The B-wing senior officer wondered whether the man had been to court that morning, but he said that he had not been to court and had not been refused bail. The B-wing senior officer thought that one of the officers checked the computer system which confirmed that the man had not gone out to court. The B-wing senior officer said that he spoke to the healthcare senior officer to tell him that the information he had given about the man was incorrect.

An ACCT assessor from B-wing saw the man on 4 April for a 24 hour ACCT case review. She had had some previous contact with him in the time he had been on the wing, but only on routine matters such as booking visits. She said the man was a quiet man who tended to keep himself to himself. When she asked the man on 4 April whether he had applied for bail, he said that his bail hearing was going to be in June. The B-wing ACCT assessor showed the man the entry in the ACCT form. He asked if that was the reason he had been checked every hour the previous night and said he was not too happy about that. He told the B-wing ACCT assessor that he was fine. The B-wing ACCT assessor noted the man's mental state that day as "stable and happy". She said that she and the B-wing senior officer agreed that the ACCT form should be closed.

On 12 April, the man's solicitor visited him to discuss his forthcoming trial. The solicitor told my investigator that the man seemed in a much better frame of mind compared to when he telephoned her on 3 April. The solicitor also said she was extremely surprised when she heard subsequently that the man had taken his life.

The Metropolitan Police gave my investigator copies of the statements they had taken from prisoners in B-wing. Only two prisoners had had anything more than superficial contact with the man. Of these two, one prisoner said that although he did not know the man's name, they had had several conversations over the last few weeks. The man had spoken about his personal life saying that he was depressed because he had lost all his money and really missed his wife. This prisoner said

that the man went to court about three weeks before his death. After that he became very withdrawn and no longer responded when this prisoner said good morning.

The other prisoner to have more substantial contact with the man said that he and the man would talk during association. The man said that he was innocent of the allegations made against him and was worried that he would lose his house. This second prisoner thought that the man seemed depressed. This second prisoner said that the last time he saw the man was at about 4.30pm on 17 April. They spoke for around half-an-hour. While they were talking, another prisoner asked him why his cell was different to the other cells. The second prisoner said that his cell was designed to stop people from committing suicide. He added that the only way to commit suicide in his cell would be to cut your wrists. The man said that cutting your wrists would not be successful.

The man telephoned his daughter a number of times on the evening of 17 April. The man's daughter told my Family Liaison Officer that it was not particularly unusual for him to phone several times in a single day. Her father asked whether she had got her visiting order for the coming Saturday, and said that he was looking forward to seeing her. He told her that he loved her.

### *The discovery of the man's death*

During the early morning roll check on 18 April the man was found to be hanging from a ligature tied to the cell window. The officer who found him alerted an officer support grade (OSG)[1] who was working with her and she also telephoned for further support. The officer who did the roll check told my investigator that her understanding was that during night time patrol state a cell should be unlocked only in the presence of two trained officers. She said that an OSG does not count for this purpose. She added that no one said anything to her subsequently to say that she should have gone in before the arrival of more staff. Other officers responded to the call for support, arriving within a few minutes, they went into the cell and cut the ligature to release the man.

A nurse arrived and on checking the man recorded that he was cyanosed[2] and that his body was stiff. Another nurse who had also responded told my investigator that when he arrived the other nurse told him that he had attempted cardiopulmonary resuscitation (CPR) on the man but had got no response. This nurse said he also examined the man and also noted that he was cyanosed with some evidence of rigor mortis. This nurse thought that the man had been dead for two or three hours so he did not attempt CPR. He telephoned the duty doctor to ask him to attend to officially pronounce death.

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[1] Officer Support Grade (OSG) staff do not receive the same level of training as Prison Officers. They carry out tasks that do not involve a great deal of prisoner contact.

[2] Cyanosis is when the extremities of the body turn blue through the absence of oxygen.

### *The letters found in the man's cell*

When the man's cell was searched by the police on the morning of his death three torn-up letters were found in the waste bin. All three letters were addressed to his daughter. One of the letters was dated 31 March. The other two were undated. The man refers to his wife in all three of his letters. In one of them he wrote:

> "Part of me still loves *****. I know what she's done but it all happened so fast. It's just I can't live without her …"
>
> "I have no future anymore I hate the thought of fighting ***** in court."
>
> "I bet ***** will be happy, it saves her going to court and having to perform now. My heart is broken she always knew I couldn't live without her."

### *After the man's death*

The Governing Governor of Brixton together with one of Brixton's family liaison officers visited the man's daughter to break the news. They arrived at the house at about 9.30am. The man's daughter was at home as was her husband.

The man's daughter became extremely upset on hearing the news and the Governing Governor and family liaison officer left the house so her husband could console her. Before leaving, the family liaison officer gave the husband his mobile telephone number and told him that he and the Governing Governor would return if his wife wanted them to do so. The Governing Governor and family liaison officer drove a few streets away and parked their car. Soon after the husband telephoned to ask if they could return. They did so and spent around 40 minutes with the couple giving as much information as they knew about the circumstances.

The man's daughter was offered the opportunity to visit the prison if she wished but she declined. Brixton agreed to pay the man's funeral expenses. The family liaison officer left the man's daughter his telephone number to allow her to ask further questions about the circumstances surrounding her father's death. The family liaison officer told my investigator that the man's daughter said that her father would talk to her about suicide, but she would tell him that he must not do anything to himself and he would agree to stay strong.

Because the man's wife was due to testify against him at his trial, it was the police who visited her to break the news of his death.

## CONSIDERATION OF THE ISSUES

### *The man's clinical care*

One of Brixton's doctors recorded on 7 February 2007 that he had referred the man to the psychiatric outreach team. My investigator asked Brixton for copies of all documentation held by the psychiatric outreach team for the man but was told that no such documents existed. This was not the first investigation where I have discovered a break-down in the arrangements for obtaining a review by the psychiatric outreach team.

**The Governor and healthcare manager should urgently review and revise the existing processes for referrals to the psychiatric outreach team.**

In response to the draft version of this report the solicitors acting for the man's daughter queried the actions of the nurse who saw the man at 7.30am on 11 January. They questioned whether she should have called immediately for an ambulance rather than waiting 15 minutes for the doctor to arrive. I asked the clinical reviewer to comment and her response was to say:

> "The review showed that the nurse called for medical advice on the patient as she expected him (the doctor) to arrive within 15 minutes. This was a practical response. It is not clear what time the overdose was taken and it is beyond our competence to comment on whether or not the 15 minutes would have affected the outcome."

### *Opening and closure of the first ACCT form*

The first ACCT form was opened on 11 January after the man took an overdose of his in-possession medication. On 12 January, the man was visited in hospital by the suicide prevention co-ordinator, a trained ACCT assessor. This assessor estimated that he spent around two hours with the man who said he was adamant he would never attempt such a thing again. I commend the suicide prevention co-ordinator for his diligence.

The man remained in hospital until 20 January, when he returned to Brixton. The ACCT form was kept open for almost two weeks and it was managed correctly in this time. The form was closed on 24 January. At a case review that day with a senior officer and another officer, the man said that he regretted taking the overdose and was keen to move on with his life. I am satisfied that the decision to close the ACCT form was a reasonable one.

### *Opening and closure of the second ACCT form*

The second ACCT form was opened on 7 February by one of Brixton's doctors. He did so when the man attended a consultation reporting that he was feeling depressed and was having trouble sleeping. The doctor noted that the man denied having suicidal ideation.

On 8 February, the man was seen for an assessment interview by an ACCT assessor and a senior officer. The ACCT assessor recorded the man stating that he was not suicidal and had no thoughts of self-harm. The two officers agreed to close the ACCT form.

During his interview with my investigator, the doctor said he was surprised the ACCT form was closed the day after he had opened it and without any reference to a clinician. He thought that if an ACCT form was opened by a clinician, then a clinician should be involved in its closure.

The ACCT process does not in fact require involvement by a clinician in the way suggested by this doctor. Even so, I have some sympathy with his viewpoint. However, what the ACCT process does require is for the care of prisoners at risk to be multi-disciplinary. The multi-disciplinary team can include healthcare staff. In my opinion it would have been a matter of good practice for healthcare to have been asked to contribute to the case review held on 8 February.

**The Governor should remind staff that the ACCT process is a multi-disciplinary one.**

***Opening and closure of the third ACCT form***

The third and final ACCT form was opened on 3 April. The man had telephoned his solicitor to ask about a renewed bail application. To her, he seemed quite dejected on being told there was little point in applying as his circumstances were unchanged from the time he had been refused bail in November 2006. The man's solicitor telephoned Brixton to say she was concerned about the man and an ACCT form was opened. Unfortunately, the entry made by the officer who opened the form indicated that the man had been refused bail. When staff established that the man had not been to court and had not therefore been refused bail, the ACCT form was closed.

The B-wing ACCT assessor spoke with the man before closure of the ACCT form and noted that he was stable and well. The B-wing senior officer also spoke with the man and he too thought that the man seemed well.

The B-wing senior officer spoke in his interview about options for the man's care had the message from the man's solicitor been properly recorded in the ACCT form. He said that the ACCT form could have been kept open with a note made of the date of the man's next court appearance. The man would then have had a case review at some point around that date.

I conclude that the man's solicitor should have been contacted for clarification. Had that been done, it is likely the ACCT form would have been kept open.

***Whether staff should have realised that the man was at risk***

As we have seen, ACCT forms were opened for the man on three separate occasions. All three were closed in due course, the last two each being closed within 24 hours of being opened. The man also took two overdoses in the few months leading up to his death. The man took the first overdose before he arrived in Brixton. He said that his reason for taking the overdose was not to harm himself but instead to gain sympathy from his wife.

The man's daughter thought that this information should have been entered in her father's records at the time. If it had been recorded it would have been available to staff when they considered his mental health state after his second overdose (the second overdose occurred while the man was in custody and resulted in the opening of the first of the ACCT forms). The man's daughter also pointed out that the information would have been available had Brixton obtained her father's community clinical records. And on this matter, I note that one of the recommendations made in the clinical review relates to the obtaining of community clinical records.

**The Prison Health partnership board should consider the issues raised in the clinical review and develop an action plan to implement all appropriate recommendations made by the review panel.**

Despite the three ACCT forms and the two overdoses, there was little else about the man's behaviour to give staff cause for concern. The suicide prevention co-ordinator visited the man in hospital on 12 January and spent around two hours with him carrying out an ACCT assessment. Notwithstanding his overdose the previous day, the man was able to speak positively about the support of his daughter and his first wife and declared that he would never try to harm himself again. Even with the opening of the second ACCT form, the doctor who opened it acknowledged that it was the recent overdose that was the most important factor in his decision.

Although the man generally seemed to have kept himself to himself at Brixton, two prisoners gave statements to the police about their contact with him. Both said that they thought the man seemed withdrawn or depressed.

In contrast, the man's solicitor told my investigator that when she visited him on 12 April he seemed in a much better frame of mind than when he telephoned her on 3 April. Moreover, the man's daughter told my staff that her father seemed his usual self both when she visited him on Saturday 14 April and when he telephoned her several times on the afternoon or evening of 17 April (the evening before his death).

The letters written by the man and found in his cell after his death appear to give an insight into his thoughts. But from his general demeanour and behaviour it would not seem he was giving out any obvious signals for staff to have recognised.

I have already indicated my view that the last ACCT form could and perhaps should have remained open pending another bail application. However, what we can never know is whether keeping the ACCT form open would have made any difference to the eventual outcome.

### *The delay before staff entered the cell*

There was a delay of a few minutes between the man being found hanging by the officer who did the morning roll check and staff entering the cell. The delay occurred while this officer waited for the attendance of further trained staff.

Brixton's local instruction for opening cells at night time include that under normal circumstances a single occupancy cell should not be entered unless two members of staff are present. The instruction also states that the saving of life is paramount and that aid must not be delayed.

A governor told my investigator that the officer who did the morning roll check was correct in saying that the reference in the local instruction to 'two staff' does mean two trained members of staff and OSGs do not count for that purpose. The governor also explained that there had been occasions when prisoners had feigned a hanging in order to lure officers into the cell. As a result, officers must always be aware of the potential conflict between the need to preserve life and the need for security.

In the man's case, it was clear once he had been examined that he had died some time previously. In other circumstances, a delay of just a few minutes in entering a cell can make the difference to whether or not a life can be saved. However, I also acknowledge the point about security. Provided staff always bear in mind the two competing priorities of security versus preservation of life, it will always be a matter of personal judgement whether they should wait for further support before entering a cell.

### *The man's claim that he was assaulted in his cell*

The duty governor was asked to visit the man in hospital on the afternoon of 11 January. This was to explore an allegation that an officer had assaulted him in his cell that morning and another allegation that he had been handcuffed to his hospital bed. The man told the duty governor that he had not been assaulted, but thought that the officer who had unlocked him at around 7.00am should have arranged for him to be sent to hospital at around that time after he mentioned he was not feeling well. The man denied claiming that he had been handcuffed to his hospital bed, although he did complain about being handcuffed to officers[1].

The duty governor wrote a report about the man's complaints and passed it to the Governing Governor for investigation. Brixton confirmed to my investigator that an investigation was conducted and that the man's complaints were not upheld.

[1] Prison security requirements mean that prisoners at outside hospitals are usually kept handcuffed to one or two prison officers.

***The letters found in the man's cell***

Three torn-up letters were found in the man's waste bin after his death. All three were for his daughter and all three indicated he was considering taking his life. One of the letters was dated 31 March. The man's daughter questioned why her father's cell had not been checked given that he had previously taken an overdose.

In prisons, it is the responsibility of prisoners to keep their cells clean. This includes emptying their waste bins, which they do by emptying the bin into a communal bin on the landing. Even for prisoners on open ACCT forms, the monitoring checks carried out for their wellbeing do not routinely include searches in their cells and among their possessions for anything they may have written.

## RECOMMENDATIONS

I make the following three recommendations. The first two appeared in the initial draft of this report and the Prison Service's responses are set out below each of those recommendation. The third recommendation is a new recommendation.

1. I recommend that the Governor and healthcare manager urgently review and revise the existing processes for referrals to the psychiatric outreach team.

> ***Prison Service response:*** *Recommendation accepted. Review to be undertaken shortly as part of a wider consideration of utilisation of resources. Also additional resources have been made available for mental health services and review will inform their use. Target for completion is August 2008.*

2. I recommend that the Governor should remind staff that the ACCT process is a multi-disciplinary one.

> ***Prison Service response:*** *Recommendation accepted. New Suicide Prevention Policy and Staff Information Notice published April 2008 which refers to this specifically. Implementation action plan developed and underway. ACCTs are discussed each morning at the Safer Custody meeting. Full and well attended Safer Custody meetings are held monthly.*

3. I recommend that the Prison Health partnership board should consider the issues raised in the clinical review and develop an action plan to implement all appropriate recommendations made by the review panel.