Investigation into the circumstances surrounding the death of a man at HMP Brixton in May 2006

Report by the Prisons and Probation Ombudsman for England and Wales

April 2009

This is the report of an investigation into the circumstances of the death of a man at HMP Brixton on 27 May 2006. The man was found hanging in a communal shower room. It appears his date of birth may have been wrongly recorded by the Prison Service. According to his father he was 31 years old when he died.

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

The investigation was carried out by two of my colleagues. Lambeth Primary Care Trust agreed to carry out a review of the man's clinical care and treatment while at Brixton. This report was not received at my office until September 2007, delaying the issue of this report. However, I am most grateful to the clinical reviewer for the extreme thoroughness of his review on which I have drawn extensively.

The Prison Health Unit of the Department of Health provided observations on the man's alcohol detoxification programme. I would also like to thank the Governor of Brixton, and his staff for their help in this investigation.

The man was an Irish national who was remanded into Brixton on 20 April 2006 pending extradition proceedings connected to an offence that occurred in Dublin in 2005. The prison wing where the man was located contained a number of other Irish prisoners and there were six with whom the man associated.

On 23 May 2006, the man was made subject to special monitoring when he made a comment to a family support worker in the prison suggesting that he might be at risk of self-harm or suicide. Other than indicating on reception to the prison that he had self-harmed in the past, that was the only time that the man said anything to indicate to staff that he might have been at risk. In contrast, the man spoke about suicide with his companions and asked one of them to write a note for him as his will, giving directions for his cremation. Staff were never made aware of this.

I conclude that there were a number of missed opportunities to gain information about the man's mental health history and risk that could have greatly improved the management of his care at Brixton.

I have made four recommendations. One is about dealing with prisoners who obscure cell door observation panels. Two are about access to and the security and safety of the shower room on G-wing. The other recommendation is about the appointment and support of family liaison officers. The clinical review makes a further 19 recommendations about the man's healthcare and about suicide prevention procedures that I fully endorse.

Stephen Shaw CBE
Prisons and Probation Ombudsman **April 2009**

CONTENTS

SUMMARY

The man was born in Dublin. His prison paperwork records his date of birth as 12 September 1973, but the man's father has told my office that his son was in fact born on 12 September 1974.

In 2005, the man was allegedly involved in an incident in Dublin that the Garda (the Irish police force) dealt with as suspected murder. The man left Ireland and came to England.

For some time, the man lived at a residential unit in east London. The residential unit is part of the Spitalfields Crypt Trust that provides support and accommodation for people with drug or alcohol problems (the man had been an alcoholic for a number of years). In April 2006, the man's whereabouts became known to the police. He was arrested, charged with murder and taken into custody. On 20 April 2006, the man was remanded into HMP Brixton pending proceedings for his extradition back to Ireland.

During the reception health screening process on arrival at Brixton, the man was asked about self-harm. He said that he had harmed himself in the past, but had no present thoughts of self-harm. He repeated these answers when he was seen by an officer for a cell sharing risk assessment. The man was also seen by a doctor that day who prescribed him medication for opiate detoxification and for symptoms of alcohol withdrawal. The doctor also prescribed medication for depression. The doctor noted that the man was a schizophrenic (a view he based upon the man's own report of his community prescribed medication and his report of having been under the care of a community mental health clinic). The doctor recorded that the man's mood was satisfactory. The man was referred to the mental health outreach team by the doctor (a nurse made a similar referral the following day).

Once the reception process was completed, the man was allocated to a cell on G-wing. At that time, G-wing was the first night centre as well as holding remand prisoners and those going through a detoxification regime.

As might be expected of a London prison, Brixton holds prisoners of many different nationalities. At the time that the man was on G-wing there were a number of other Irish prisoners on the wing, with six of whom he became friends. These included the man's cell-mate and another prisoner who knew him from time they spent together at Mountjoy prison in Ireland.

From 13 May 2006, the man began to miss out from collecting some of his prescribed medication. After 16 May, he ceased to collect any of his medication. Records of this were made in the man's prescription charts but this information does not seem to have been passed back to the healthcare unit.

The officers on G-wing consistently described the man as a happy and chatty person who got on well both with staff and with other prisoners. They had no fears for the

man's safety and so it came as a surprise to them when an F2052SH[1] form was opened for him on 23 May. Whilst healthcare staff were aware of the man's recent past history of self-harm, the wing staff were not.

The F2052SH form had been opened by a family support worker employed by a local charity. She opened the form when the man told her that he was facing a life sentence and said he would prefer that they had him dead rather than alive (presumably referring to his extradition back to Ireland). A Senior Officer who knew the man quite well spoke to him on the afternoon of 23 May as part of the suicide and self-harm procedures, and again on the following day. The Senior Officer's note of their conversation on 24 May included that the man had said he had no intention of harming himself. Even so, the Senior Officer decided to keep the F2052SH open and it remained open until the man's death. However, the evidence of all the officers was that the man's behaviour while the F2052SH form was open was no different to how it had been previously.

The man had two visitors on 26 May. One visitor was a manager from the Spitalfields Crypt Trust. The other was the man's solicitor. Both thought that the man seemed emotionally well.

On the morning of his death (27 May), the man was seen by a doctor for an F2052SH review. The doctor was visiting G-wing as part of his general medical rounds when he was asked to see the man. The doctor did not have the man's medical records. As the doctor is also a native of Dublin, he and the man spent time chatting about the city and the doctor thought that this allowed them to establish a rapport. The man told the doctor that he had been misunderstood by the charity worker who opened the F2052SH form. He had not intended his remarks to her to have been taken literally. The doctor was satisfied that the man was not at risk.

From around 11.30am, prisoners on G-wing were served lunch. One of the officers spoke to the man at about 12.10pm. He asked the man if he had had his lunch and the man said that he had. At the time the man was sitting on the landing having a cigarette with one of his friends. The man then told his friend that he was going to have a shower. (Each landing on G-wing has a communal shower room. There are no doors fitted to these rooms so prisoners can access them at any time.)

Following lunch, prisoners were locked into their cells and counted. When the count was made at around 12.30pm, officers realised that the man was missing. A search was made and, when one of the officers went into the shower room, she saw the man hanging from a ligature that had been tied to a pipe running across the ceiling. The officer shouted for assistance and other officers entered the room. Staff cut the ligature, placed the man on the floor and commenced cardio pulmonary resuscitation (CPR). Healthcare staff, including a doctor, responded on being alerted that there was a Code One[2] incident. Despite their efforts to resuscitate the man, he was pronounced dead by the doctor at 12.47pm.

[1] The F2052SH process was used at that time to monitor and support prisoners judged at risk of self-harm. The F2052SH process has since been replaced by ACCT (Assessment, Care in Custody and Teamwork).

[2] Code One indicates a possible life threatening incident.

Following the man's death, a note was found in his pocket stating that he wanted his body to be cremated and giving directions about the disposal of his ashes. The man had difficulties with literacy so had asked another of the Irish prisoners to write the note for him. It seems that the man spoke to the other Irish prisoners about suicide, but they did not take his comments too seriously and did not report these conversations to the officers.

This investigation has found that Brixton missed several potential opportunities to obtain more insight into the man's state of mind. The first was a letter from one of the managers at the Spitalfields Crypt Trust. The letter referred to the man's history of self-harm and reported him as saying many times that, if he should ever return to prison, he would commit suicide. A copy of this letter was contained in the records that my investigator obtained from Brixton. However, none of the staff interviewed during the investigation could recall seeing the letter.

Secondly, Brixton failed to obtain the man's community medical records. They included important information about his risk of self-harm or suicide. The man had told Brixton that he did not have a GP, but he also reported that he was taking prescribed medication.

Finally, despite the separate referrals by the reception doctor and a substance misuse nurse to Brixton's psychiatric outreach team, he was never reviewed by that team and the two referral forms have never been traced.

This report makes 23 recommendations. Of these, 19 are healthcare related and derive from the clinical review.

THE INVESTIGATION PROCESS

The investigation was opened on 7 June 2006. My colleagues visited Brixton and met a number of prison staff including the Governor, the prison's family liaison officer and a representative from the Prison Officers' Association. My investigators also met a representative from the Independent Monitoring Board (IMB). My investigators informed them of the nature and scope of the investigation. Notices were issued to staff and prisoners notifying them of the investigation. Eighteen members of staff and seven prisoners were interviewed.

Lambeth Primary Care Trust agreed to carry out a review of the man's clinical care and treatment while at Brixton. A member of staff from the Prison Health Unit of the Department of Health provided observations on the man's alcohol detoxification programme.

One of my Family Liaison Officers contacted the man's father to inform him of the investigation. My family liaison officer, together with my investigator visited the man's father and one of his daughters, to take details of their concerns. The man's sister said that her brother had very visible scarring to his arms from self-inflicted cuts. She thought that he should have been monitored more closely to try to prevent further acts of self-harm. She also thought her brother should have been referred for a psychiatric assessment.

The man was angry that there was open access to the shower room where his son was able to hang himself out of view from prison officers[3]. The man thought that a lockable door should be fitted to prevent unauthorised access to the shower room. Apart from the fact that his son was able to use the shower room in order to take his life, the man's father pointed out that the room could be used by prisoners to carry out assaults. However, even without a door, the man's father thought that it should be possible for staff to deploy themselves in such a way that would prevent prisoners from going into the shower room at lock-up time.

Both the man's father and sister said that they were upset at the way Brixton dealt with them following the man's death. Contacting the prison's family liaison officer had been difficult and there was a substantial delay in the man's ashes being sent to them. They then faced two further substantial delays before Brixton firstly reimbursed them for the funeral director's fees they had incurred and then only later reimbursing them for the interment fees. The family were also upset that Brixton's family liaison officer initially told them that the man was found dead in his cell, rather than in the shower block as they later learned was the case. Another matter that caused the family great anguish was the apparent loss of the man's belongings and the long delay before this was confirmed.

[3] The annexes contain a plan of G-wing showing the shower room and its open access.

HMP BRIXTON

Brixton first opened in 1819. Its primary role 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 has four main residential units. G-wing, where the man was located, comprises four floors. It contains 151 cells of which 61 are double cells. Brixton has recently gone through reconfiguration, but at the time the man was there G-wing was the first night centre and induction unit. G-wing also held remand prisoners and those going through detoxification.

The last inspection of Brixton by Ms Anne Owers, Her Majesty's Chief Inspector of Prisons was an unannounced inspection in February and March 2006. Ms Owers's report of her findings included:

> 'The inspection found continuing improvement [since the previous inspection] in some areas. Prisoners were out of their cells a great deal, for longer periods than we have seen in most public sector local prisons …
>
> 'Brixton suffers from a poor build environment and little had been done since the last inspection to address this …
>
> 'Delays in agreeing and providing the significant capital investment had impacted badly on the morale of staff, and on the outcomes for prisoners …
>
> 'In spite of the obvious enthusiasm of senior managers, the improvements that have been put in place, and the commitment of many staff, Brixton was still not performing sufficiently well against three of our four tests of a healthy prison – respect, purposeful activity and resettlement … Managers have ensured that Brixton has developed a sense of purpose and a positive vision of what can be delivered. However, in order for that vision to be realised, it needs capital resources from the centre …'

One of the concerns raised by the man's father to my staff was the potential for prisoner-on-prisoner assaults in the shower room. This matter was put to Brixton. In response, Brixton confirmed that there had been five such assaults in the shower rooms on G-wing during the previous two and a half years. The response went on to indicate that Brixton accepted that lockable doors needed to be fitted to the shower rooms. In the meantime, a notice to staff to check the shower areas periodically would be issued.

KEY EVENTS

20 April to 25 May

On 20 April 2006, the man was remanded into Brixton from Bow Street Magistrates' Court. He had been arrested that day in connection with a suspected murder in Dublin in 2005. The man was an Irish national and Bow Street Magistrates' Court was the court responsible for dealing with his extradition proceedings.

When the man arrived in Brixton one of the documents that came with him was a Prisoner Escort Record (PER) form. This is a form that is completed when one agency, such as the police, pass a prisoner on to another agency such as the Prison Service. The PER form highlights possible risk factors applying to that prisoner, for instance the possibility that the prisoner might be violent, might have drug or alcohol related problems or might be at risk of suicide or self-harm. The man's PER form was ticked by the police to show that his risk categories were judged to be: violence, escape risk, suicide/self-harm, vulnerable.

Upon his reception into Brixton on 20 April, the man was seen by a reception nurse for a first reception health screening (FRHS) interview (this is part of the standard Prison Service reception process). Part of the FRHS procedure explores issues relating to self-harm. The man reported that he had harmed himself in the past, both in prison and outside. He said that the last occasion had been nine months previously. The man was also asked whether he had any present thoughts of self-harm and he said that he did not. During the health screening process, the man said that he was not registered with a GP but also reported that he was receiving prescribed medication (anti-psychotics and sleeping tablets). He said that he usually drank two bottles of whisky and 15 cans of beer (although no note was made of the period over which the man would consume these amounts). The man reported that he used heroin on a weekly basis and cannabis daily. The reception nurse made a separate entry in the man's clinical record:

> '… Currently on anti-psychotics but says never been treated by psychiatrists. Most recent [self-harm] 9 months ago – denies any current thoughts of [self-harm/suicide]. Open and honest conversation. Good engagement. Good eye contact. [Plan] –> [refer for] mental health [assessment] ...'

After seeing the reception nurse, the man was seen by one of the prison doctors (the first doctor). The man reported that he had been diagnosed with schizophrenia. The first doctor prescribed several drugs for the man including dihydrocodeine for opiate detoxification as well as medication for depression and medication to help with the effects of alcohol withdrawal. The first doctor noted that the man's mood was satisfactory. Even so, the first doctor referred the man to the psychiatric outreach team. At interview, he said he made the referral in part because of the man's declared diagnosis of schizophrenia and the community prescribed drugs he was taking. However, there was no other record that the man had schizophrenia and no efforts were made to obtain his community clinical records.

On the same day, the man was seen for a cell sharing risk assessment by his landing officer. The man said that he had no concerns about sharing a cell. He reported that

he had self-harmed in the past but said he was 'fine now'. Once the reception process was completed, the man was located into a shared cell on G-wing.

On 21 April, the man was seen by a nurse from Brixton's Substance Misuse Team. Among other things, the nurse recorded the man saying that he had past diagnoses of schizophrenia and depression. As the nurse did not have the man's clinical records she relied entirely on what he told her. This caused her to record inaccurate information. The nurse's plan included referring the man to the psychiatric outreach team. At interview, the nurse maintained that she made such a referral. She said that she always does so for every prisoner with mental health problems. She said the fact that the prison doctor had recorded making a referral the previous day would not have prevented her from also making a referral.

The Senior Officer had worked at Brixton for four years. He was not a substantive senior officer but had been promoted temporarily into that grade since the end of 2005 and had been working on G-wing for a year. He described the man as "a nice chap". He said that they chatted frequently and had a laugh. The Senior Officer said that his first contact with the man was when he asked to move to a single cell. The Senior Officer told the man that G-wing does not have a sufficient number of single cells. The only way he could move to a single cell would be if he had a job in the prison as staff tend to reserve the privilege of a single cell for those who are working. The man said that in that case, he wanted a job. Thereafter, the man would ask every day if he could have a job. No posts were available, but staff allowed the man to give a hand to those prisoners with jobs.

After 16 May it appears that the man failed to collect any of his prescribed medication. This was not followed up by healthcare staff.

A charity worker for Adfam, an agency that supports families of prisoners with drugs or alcohol related problems, also supports prisoners during their induction into Brixton and she met the man on 19 May. He approached her that day to ask her to contact a manager he knew from a rehabilitation unit (the Spitalfields Crypt Trust). The man wanted the unit manager to visit him at Brixton. The charity worker estimated that she spent between 10 to 15 minutes with the man. She said that the man was quiet, but he did not seem unduly troubled.

The next time that the charity worker met the man was on 23 May. She told him she had contacted the manager from the rehabilitation unit who said that he was very willing to visit. The charity worker told the investigators that the man did not seem to take in what she was saying. She then left the man to see other prisoners. About half an hour later, the man approached her and said that he was facing a life sentence. He could not see he had a future and would rather that 'they had him dead than alive'. The charity worker was concerned by these comments so she asked the man if he had ever self-harmed or made suicide attempts in the past. The man said that he had, and showed her the scarring on his arms. As a result, the charity worker opened an F2052SH form so that the man would be made subject to special support and monitoring.

The F2052SH process required that prisoners were seen by the senior officer in charge on the same day the form was opened and as soon as possible that day. On

23 May, the Senior Officer saw the man at 4.00pm. The Senior Officer told my investigators that, from his previous contact with the man, it seemed out of character for him to be made subject to F2052SH monitoring. His comment to the man was: 'What's this about mate?' The man replied that he was just a little bit down because he expected to be extradited back to Ireland and was worried about his court case. He also said that he tended to have ups and downs due to his use of drugs over many years. The Senior Officer said that the man was downplaying the issue of suicide/self-harm as much as possible, and mentioned once more that he would like a job and a single cell. The Senior Officer told the man that he would have to remain in a double cell for the time being.

The Senior Officer did not note on the F2052SH form how frequently the man should be observed. He explained to my investigators that prisoners deemed at high risk and requiring frequent observations were managed in the healthcare unit. The Senior Officer did not think that the man fell in that category. For prisoners not considered at high risk there was a set protocol understood by all officers. This was that there would be two contacts with the prisoner in the morning and two in the afternoon. At night time, the prisoner would be observed every hour.

The Senior Officer reviewed the man again on 24 May. No member of healthcare was involved in the review but the Senior Officer was accompanied by one of the wing officers. The Senior Officer wrote the following summary of the review:

> 'Stated that he is not a self-harmer and has no intention of suicide. Stated … worried about his trial but this is not a reason why he would harm himself. Attempted suicide, but this was fifteen years ago when he was young. He has overcome his heroin addiction, now well integrated in G-wing with staff and other prisoners. I personally have no further concerns [for] the man.'

The Senior Officer could have closed the F2052SH that day but he chose instead to keep the form open. He said that his reason for keeping the form open was that, even though he knew the man by sight, he did not feel he knew him well enough as a person to close the form so soon after it had been opened. The Senior Officer went on to say that he was shocked when the man later took his life. He said that it was typical with prisoners at risk of self-harm to be withdrawn. But the man was not like that, he was always laughing and joking. The Senior Officer said that all of the staff were just as surprised as he was.

The first officer, who was responsible for dealing with jobs for prisoners on G-wing, told the investigators that the wing holds 220 prisoners. He said most of them wanted jobs, but there were only around 30 available. For a prisoner to be offered a job, his behaviour must be reasonable and he must present no security risk. If these criteria are met, the prisoner will go on a waiting list until a job becomes available. The man had a reputation for being well behaved so he was placed on the waiting list. The first officer said that the man would approach him most days to ask about a job, but took it well each time he was told that there was nothing for him yet. The first officer said that, in addition to that contact, he also saw the man out and about on the wing. The man was quite a cheerful and outgoing person who would chat to the staff and to his large group of friends. The first officer said that the man's friends were other Irishmen whom he knew from outside of prison.

The first officer said that it seemed strange to him when an F2052SH form was opened for the man. He was still smiling and was his usual self even on the day the form was opened. The first officer said that he asked the man if he was alright and he replied that he was fine. Prisoners subject to F2052SH monitoring often tend to be subdued and withdrawn. This was not the case with the man.

G-wing's cleaning officer told the investigators that as well as dealing with the wing cleaners she also deals with the prisoners working at the servery. As with the first officer, the cleaning officer found that the man would approach her asking for a job. The cleaning officer said that the man was always polite and respectful and seemed quite a nice man to talk to. However, theirs was a fairly superficial relationship so she did not feel that she properly got to know him as a person.

Another officer, the second officer, said that the man was a happy prisoner. He was a polite man who never caused the staff any problems. He also seemed to get on well with the majority of other prisoners. The second officer thought that the man was coping well with prison life and he was surprised to find out that an F2052SH form had been opened for him. The second officer said that he would try to monitor prisoners on open F2052SH forms through the day. Throughout the time that the man was subject to F2052SH monitoring he remained his usual self.

The third officer gave similar evidence about how the man seemed to be coping. He described him as a happy-go-lucky type of person. The third officer said that on 23 May he was about half way through working a week of night shifts. He said he was shocked to find out that an F2052SH had been opened earlier in the day for the man. He asked the late shift staff for the reasons. The third officer said that, in line with his usual practice, he went to speak with the man to check how he was. The third officer said that the man's mood was no different that night to how it usually was.

For much of the time through the night of 23 May and into 24 May, the observation panel in the man's cell door was obscured (it is not known whether it was the man or his cell-mate who was responsible for doing this). This meant that the third officer was unable to look into the cell to check on the man. The third officer explained to the investigators that, while officers carry keys at night time, the keys are kept in a sealed pouch. The seal should be broken only in the case of an obvious emergency, for example a fire inside a cell. However, in the man's case the third officer knocked on his cell door at regular intervals through the night and obtained responses from him. He made a record of these interactions in the man's F2052SH form. The third officer said that another option for dealing with the situation would have been to have contacted one of the two Night Orderly Officers[4] on duty to ask them to open the cell. The third officer said that he would have contacted the Night Orderly Officer if the man had not responded each time that he knocked on his door. However, given that the man did respond, the third officer felt that he had dealt with the situation in an appropriate manner.

Another officer gave similar evidence to other officers about the man being an approachable person who was easy to speak to.

[4] The Night Orderly Officer is the officer in charge of the prison at night time.

26 May – the day before the man's death

On the morning of 26 May the manager from the Spitalfields Crypt Trust, visited the man (the man had been living at one of the Trust's residential units, for about nine or ten months before his arrest). The visit lasted about 25 minutes. The man told the manager about the circumstances surrounding the offence on which he was facing extradition. When he heard the man's explanation, the manager told him there appeared to be grounds for mitigation and he advised him to speak to a solicitor.

The manager from the rehabilitation unit told my investigator that the man remained in a good mood throughout the interview and he left thinking that the man was okay. He said that he was very surprised when he learned that the man had taken his life. That said, the manager also mentioned that the man always said that he "would never go back to prison". The manager felt that he had not previously realised or understood the significance of these words.

The man's solicitor visited him at about 4.00pm on 26 May. She told my investigator that the man did not seem depressed that day. He knew that it would be at least a few more weeks before his extradition to Ireland. The man said that the staff were treating him well and, by the end of their meeting, he was eager to go, telling her that he had a nice meal waiting for him.

One of the landing officers thought that the man seemed a bit upset after his legal visit on 26 May. The landing officer believed that the man understood from the meeting that he was facing extradition back to Ireland and was also facing a life sentence if found guilty of murder. The landing officer said that, although the man seemed upset, there was no indication that he might be considering self-harm.

A note in the man's medical records shows that he missed an arranged appointment on 26 May for a doctor's review of his F2052SH. Nothing is recorded to suggest that wing staff were contacted by healthcare to ask why the man had failed to turn up. Nor is there anything to suggest that healthcare staff attempted to re-arrange the appointment.

27 May – the day of the man's death

On the morning of 27 May, a second prison doctor was doing his rounds on the wing when the Senior Officer asked him to see the man for an F2052SH review (the Senior Officer noticed that the man had missed seeing a doctor on 26 May for this review). At interview, the second doctor said that was the first time he had met the man. As fellow natives of Dublin, the two of them spent some time chatting about this connection. The second doctor said that, when they spoke about the issue of self-harm, the man insisted that he had been misunderstood. He said that when he met the charity worker he had used the 'throwaway' line that he: "Would rather be dead than be back in Dublin". The man said that he had not meant for the comment to be taken literally. The second doctor said that he spent some time (around 20 to 30 minutes) talking with the man. The man was laughing and joking and the second doctor did not consider him to be at risk. The second doctor made an entry in the man's F2052SH form that the man was "well now". He signed and dated the form

and entered the time as 10.10am. The second doctor confirmed that he saw the man without sight of his medical records as they would have been locked away in the healthcare centre.

This assessment took place in the wing treatment room. The Senior Officer was present, as were two nurses who were carrying out their own duties. The second doctor said that the room felt crowded and it made for a totally unsuitable environment to try to explore a person's suicide risk.

The Senior Officer had taken the man to see the second doctor that morning and he confirmed that he stayed in the room. The Senior Officer recalled them talking about Ireland and having a laugh and a joke. The Senior Officer also recalled the man telling the second doctor that he was fine. Following this consultation, the man should have been locked back into his cell. This is because at that time in the morning it is the 2's landing that is unlocked for association. The 3's landing, where the man was located, has its association in the afternoon. However, instead of locking the man in his cell, the Senior Officer allowed him to stay out and to associate with the prisoners from the 2's landing. The Senior Officer said that the man was the sort of person who could be trusted not to take advantage in such situations. As a result the man was seen more frequently by staff that day. The Senior Officer added that his view is that it would be better for prisoners to be out on association all day rather than being locked in their cells.

The cleaning officer said that she saw the man on two occasions that morning. The first time was at about 10.30am or just after. The man again asked the cleaning officer whether she had a job for him. The second time the cleaning officer saw the man was at about 11.00am when he greeted her as he was walking past. The cleaning officer said that the man was smiling and seemed happy.

The second officer said that he last saw the man at about 12.10pm when he was sitting on the landing with a friend having a cigarette. The second officer asked him if he had had his lunch and the man nodded in reply. The second officer told my investigator that the man gave him no cause for concern. The second officer completed paperwork for the man's F2052SH form writing: "Has been out of cell today had a review and had dinner." The second officer timed the entry at 12.30pm. That was the time he completed the form, not the time that he saw the man.

Three prisoners recalled speaking to the man on 27 May. One said that the man was his usual self. They exchanged hellos but that was all. Another said that the man told them in the late morning that he was going to take a shower. He did not say that he was going to harm himself. The third said that the man was smoking a lot that morning and was acting strangely.

The man's cell-mate said that he had lain in bed all morning on 27 May and did not see the man at all that day.

The discovery of the man's death

The evidence given by the officers indicates that lunchtime is a busy, even hectic, time on G-wing. Lunch is served at about 11.30am and, once prisoners have

collected their lunch, they are supposed to return to their cells ahead of lock-up. In practice, prisoners will take their food to their cells but will then start collecting other things that they should have collected during the morning, such as tobacco. Prisoners on the 3's landing are the last to be locked up as that landing holds prisoners going through detoxification (so they have to collect medication as well as lunch). Once locked up, the prisoners are counted. The count should, in theory, be completed in time to submit the figures by 12.30pm.

The first officer was working on the 2's landing that day and the cleaning officer was working on the 1's landing. Both officers, together with another who was working on the 4's landing went to the 3's landing to help once their own landings were locked. By this time all of the cells on the 3's landing had been locked but one prisoner, the man subject to this investigation, was missing.

The cleaning officer told the investigators that she began helping to look for the man by checking from cell to cell (in case he had decided to sit in with a friend in a different cell). The cleaning officer said that at about 12.35pm she reached the end of one side of the landing and went to check the shower room[5]. As she walked in she saw the man hanging from a ligature tied to a large pipe running across the ceiling. The cleaning officer said that she ran out of the shower room and shouted that there was a Code One emergency. She said that the first officer and the officer from the 4's landing were nearby and they went straight into the shower room.

The first officer said that he ran into the shower room and put his arms around the man's waist to support his body-weight. His colleague cut the ligature and they placed the man on the floor. The first officer checked for a pulse but found none. He said that at this point the Senior Officer arrived and started mouth-to-mouth breathing while the officer from the 4's landing gave chest compressions (heart massage).

The Senior Officer confirmed that the man was already on the floor when he arrived. He said that he and one of the officers attempted to resuscitate the man and continued with their efforts until relieved by healthcare staff.

The man's clinical records contain the following entry made by the second doctor:

> "… staff found [the man] hanging in showers, commenced CPR (cardio-pulmonary resuscitation), mouth-to-mouth … code 1 at 12:38, nursing staff on scene by 12:40, I arrived 12:41, [patient] cyanosed (blue in colour) , pupils dilated, CPR continued, intubated, defibrillator applied, pupils fixed dilated at 12:47, [patient] cyanosed, no cardiac response, pronounced [dead], resuscitation discontinued."

(There were some inconsistencies in staff's evidence about the provision of CPR to the man. This is covered in detail in the clinical review).

When the man's clothing was searched, a note was found in his pocket stating that he wished to be cremated and that he wanted his ashes to be spread over his mother's

[5] This is a large, communal, shower room at the end of the landing. There is no door at the entrance to the room but once inside a person cannot be observed from outside.

and brother's graves. The man had asked one of the other prisoners to write this note for him.

The duty member for the Independent Monitoring Board (IMB) was in Brixton that afternoon. Her written report mentioned that she accompanied the Senior Officer when he broke the news to the man's cell-mate. She noted that the Senior Officer offered the man's cell mate the chance to see a Listener[6]. The Senior Officer comforted the man's cell mate and took him to the wing office for a cup of tea.

The IMB member also recorded that there was no-one from the prison care team immediately available to support staff. Later that afternoon, Brixton's Governor held a hot debrief for the staff involved in the response when the man was found. The main purpose of the hot debrief was for staff support. There was no subsequent debrief to consider possible learning points from the man's care and treatment.

[6] Listeners are prisoners trained by the Samaritans in offering emotional support to other prisoners.

AFTER THE MAN'S DEATH

Contact with the man's family

When the man was admitted to Brixton he did not provide any details about his next-of-kin. It is standard practice in the case of a death in prison custody for officers from the local police force to attend the prison. In the man's case, officers from the Metropolitan Police attended. In order to help make contact with the man's family, the police contacted their extradition unit and obtained the name and address of the man's father. The police then contacted the Irish Garda (Ireland's police force). An officer from the Garda, who knew the man, visited the family home on the same day to break the news to the man's father.

Brixton's suicide prevention co-ordinator, is also Brixton's Family Liaison Officer (FLO). On 28 May, the day following the man's death, the FLO telephoned the man's father to give his condolences, to explain his role as prison FLO and to explain what would happen next. One of the man's sisters was in the house and the FLO also spoke with her.

The prison FLO had several further telephone discussions with the man's father and his daughter. Amongst the matters they discussed were the arrangements for the man's cremation, the return of his ashes to Ireland and payment of the funeral director's fees. These were matters that the man's father and his daughter raised when they were visited on 4 August 2006 by my investigator and my Family Liaison Officer. The man's sister said that she had paid the funeral director's fees herself and had still not received reimbursement. She also mentioned that it had taken seven weeks from the time of her brother's death for his ashes to arrive. That had been a difficult time for the family as they were waiting for the ashes in order to hold a memorial service. My investigator contacted Brixton on 7 August about reimbursement of the funeral director's fees. Reimbursement was made later that week. At a later stage, the solicitors acting for the family approached my office to say that the man's interment fees had not been paid nor had his belongings been returned to the family. Brixton refunded the interment fees but the man's belongings have not been located.

Further information from prisoners

The investigators spoke with seven prisoners who knew the man. All of these prisoners apart from one are Irish.

The one non-Irish prisoner told the investigators that he works at the servery on G-wing and got to know the man through that contact. The prisoner said that among the group of Irish lads, the man was the quiet one and the others gave him a bit of hassle. The prisoner said that the staff also gave the man a hard time. The prisoner said that there were a lot of cell searches and strip searches of prisoners happening on the wing. The prisoner said that the man found strip searches particularly stressful.

The man's cell mate was aware that the man was facing extradition because of a murder charge and had said that he was going to take his life because of this. The

cell mate said that he told the man that he was being stupid. The cell mate said that the Irish prisoners had spoken about the man after his death and agreed that he had made up his mind about what he was going to do. The cell mate added that the officers on the wing were good and were unaware that the man had said anything about ending his life. The cell mate could not recall how often he and the man had been strip-searched in the time they shared a cell. The cell mate said that it was the security officers who carried out strip searches and the man had referred to them as "scum-bags."

Another prisoner said that throughout the time the man was in Brixton he periodically spoke to fellow Irish prisoners about suicide. However, he said it so many times they just did not believe him.

A prisoner who knew the man from the time they had been together in Mountjoy prison in Ireland said that in talking about his anticipated trial for murder, the man had said there were things about his case that he would not want to emerge. He did not say what these issues were however. The man said that that he was thinking of killing himself, but he was laughing and joking when he said it so the other prisoner did not take him too seriously.

A further prisoner said that about a week or two before the man's death he had been a bit depressed because of his impending extradition and trial. However, there was nothing to cause the prisoner to think that the man would take his life.

There was a further prisoner who said that the man spoke to him about suicide. This was because he was unhappy with the thought of receiving a life sentence. However, this prisoner felt that the man's intentions were not immediate. He said that when the man asked him to write the note about his wish to be cremated, he said nothing to suggest that he was going to do anything to himself in the immediate future. When he told the other Irish prisoners about the note he had written for the man, they all told the man not to be so stupid. The prisoner added that the staff at Brixton were fine. None of the prisoners told staff what the man had been saying before his death. Afterwards, however, the prisoner told the cleaning officer about the note he had written for the man. He told her that the man was expecting to be extradited, that he was anticipating a life sentence, and that as he claimed to have no family, "there was no point."

Another prisoner knew that the man was worried about being extradited back to Ireland but he said nothing about feeling suicidal. This prisoner said that the man got on well with the other prisoners and he added that the officers at Brixton were fine in the main.

The second officer told my investigators that after the man's death a prisoner told him that the man had remarked that the pipe in the shower room would be able to take his weight. The prisoner said that he had thought nothing of this remark at the time.

The letter from Spitalfield's Crypt Trust

One of the managers with Spitalfield's Crypt Trust, wrote a letter on 12 April 2006 that he marked: 'FOR THE URGENT ATTENTION OF THE ARRESTING OFFICER'. The manager's letter went on:

> "We have information on file regarding [the man's] mental and emotional condition, which we strongly believe should be taken into account during [his] detention.
>
> > "1. [He] has a history of 'self harm' and alcoholism.
> >
> > "2. [He] has attempted suicide in the past.
> >
> > "3. [He] has expressed on numerous occasions that should he ever return to prison he ***would*** commit suicide.
> >
> > "4. [He] takes medication to manage his diagnosed psychotic mental condition.
>
> "We would like to document that we feel [the man] would be at great risk of committing suicide during his detention and would recommend that he is considered "at risk" whilst in your care."

A copy of this letter was included within the set of documents for the man provided to my investigator. It is unclear where in the man's records this letter had been originally filed. None of the staff spoken to during the investigation could recall seeing the letter while the man was in custody. Nor could Brixton explain how or when the letter was received at the prison.

ISSUES AND CONCLUSIONS

Lack of psychiatric outreach assessment

The man's records show that two separate referrals were made for him to be assessed by the psychiatric outreach team. The first doctor made the initial referral when he saw the man on 20 April, the day he arrived at Brixton. The man had told the first doctor about a previous diagnosis of schizophrenia. The second referral to the psychiatric outreach team was made on 21 April by the nurse from the substance misuse team. The nurse made the referral when the man told her about past diagnoses of schizophrenia and depression. The nurse said that, even though the first doctor had made a referral to the outreach team the day before, she made a separate referral to make sure the man would be seen.

Both the first doctor and the nurse from the substance misuse team insisted at interview that they each made a referral. Despite this, the man was never seen by the psychiatric outreach team. However, this was not noticed by anyone in healthcare. Nor have the referral forms ever been located. This was a failure in delivery of care and is a matter upon which the clinical reviewer has made a clinical recommendation.

Other healthcare issues

Although the man said at reception that he was not registered with a GP, he also said that he was taking prescribed anti-psychotic medication. This should have prompted staff to question the man further about a potential community healthcare provider. I would then have expected Brixton to obtain the community records. The clinical reviewer has made a recommendation on this.

Upon arrival at Brixton, the man was prescribed a number of different medicines. From 13 May, he began to miss out collecting some of his medication, and after 16 May he ceased collecting medication altogether. This was noted in the man's prescription charts by the nurses responsible for dispensing medication on the wing. However, this information seems not to have been passed to the healthcare unit so the man was not reviewed and not asked why he had ceased taking his medication. This again is a matter upon which the clinical reviewer has made a clinical recommendation.

My investigator asked the clinical reviewer whether the man's depression and anxiety levels would have been affected when he ceased taking his medication. The clinical reviewer said that it would not be possible to predict the effects in an individual case.

I note that the man was prescribed dihydrocodeine (DF118) for opiate detoxification. I have said in other investigation reports that DF118 is not licensed for this purpose. Although DF118 was once widely used in prisons to assist with detoxification, I welcome the much more frequent use these days, including at Brixton, of Subutex and methadone.

F2052SH procedures

On 23 May, an F2052SH form was opened by a visiting family charity support worker. She did so when the man said that he was facing a life sentence and could see no future. The Senior Officer saw the man for a wing manager's review. The Senior Officer knew the man as a jovial person so was surprised that an F2052SH had been opened for him. The man said that he was just a little bit down because of his court case. The Senior Officer decided that the man was not at high risk and should be managed on the wing. Brixton's suicide prevention co-ordinator confirmed that the majority of prisoners on an open F2052SH were managed on the wing. For these prisoners he expected the F2052SH to contain three meaningful entries each day. He also said that the number of entries in the form would not reflect the actual frequency of observations made by the staff[7].

I consider the Senior Officer's decision to manage the man on the wing to have been a reasonable one. However, he made his decision without consulting healthcare and that was contrary to the F2052SH process. (The ACCT process that has now replaced the F2052SH process provides for greater integration between discipline and healthcare staff.)

Through the night of 23 May into 24 May the observation panel in the man's cell door was obscured. It is not known whether it was the man or his cell-mate who covered the panel. Nor do we know why they did so, although it is a recurring practice by prisoners in order to gain some privacy. The third officer was on duty on G-wing that night and he recorded having regular conversations with the man during the night. The third officer tried to persuade the man to remove the obstruction, but without success. The third officer could have contacted the Night Orderly Officer to ask him to unlock the man's cell door. However, given that the man responded each time that his cell door was knocked, the third officer did not consider it necessary to contact the Night Orderly Officer. I am satisfied on this matter that the third officer's judgement and actions were reasonable. However, I also consider that the man should have been spoken to the following day for an exploration of his actions of the previous night. Although the obscuring of cell flaps is mainstream, it represents a self-evident threat to safety and security. For this reason, it should always be challenged by staff.

I recommend that the Governor issue renewed guidance to staff about challenging and dealing with prisoners who obscure their cell door observation flaps.

The man's clinical records show that he missed a GP appointment on 26 May for an F2052SH review. Apart from making that entry, no further action seems to have been taken by healthcare staff. As the man was on an open F2052SH, wing staff would have to have escorted the man to the appointment. In my opinion, healthcare should have contacted wing staff to ask them to bring the man for his review to be done that day.

[7] The ACCT document requires an entry stating the required frequency of observations to be observed on each prisoner on an open ACCT form.

On Saturday 27 May, the Senior Officer noticed from the man's F2052SH that he had not yet been reviewed by a doctor. When the second doctor came to the wing as part of his morning rounds, the Senior Officer asked him to see the man. The second doctor said that as fellow Dubliners they spent some time chatting about this connection. The man insisted that he had been misunderstood when he made what he claimed was a casual remark to the charity worker on 23 May. The second doctor said that the man laughed and joked throughout the 20 to 30 minutes that they remained together. The second doctor was satisfied that the man was not at risk. The second doctor saw the man without his clinical records. These were locked away in the healthcare unit. Of course, if the man had been seen by a doctor on Friday 26 May as was originally intended, he would have been seen in the healthcare unit and his clinical records would have been with the doctor. If the doctor had had access to the man's clinical records, that might have helped in the assessment of his potential risk. The doctor would also have noticed that the man had not been assessed by the psychiatric outreach team despite the two referrals made for him.

The environment in which the F2052SH review took place, warrants comment. The second doctor saw the man in the G-wing treatment room where the Senior Officer and two nurses were also present. I agree with the second doctor that this was a totally unsuitable environment in which to explore such a sensitive matter as a person's potential risk of suicide.

The letter from the Spitalfields Crypt Trust

The documents received at my office from Brixton about the man included a letter from a manager at the Spitalfield's Crypt Trust. The manager marked the letter for the urgent attention of the arresting officer. The manager explained that the man had a history of self-harm and had attempted suicide. He referred to the man having a diagnosed psychotic mental condition for which he was receiving medication. The letter went on to say that the man was felt to be at great risk of committing suicide during his detention. This letter clearly contains very important information. However, it has not proved possible to find out how and when it came to be received at Brixton and no one spoken to during this investigation could recall seeing it.

The shower room and other issues connected to G-wing

The man's father was concerned about the open access to the communal shower room. The man occupied a shared cell and this limited his opportunities for harming himself in his cell. What the man would have known, however, is that from just after 12 midday the shower room would probably be unoccupied while prisoners finished their lunches and were getting ready for lock-up. During this time, staff would have been very busy and once inside the shower room the man would be out of sight. This was the opportunity that the man took. I share the man's father's concerns about this. His father also pointed out that open access to the shower room allowed for the possibility of unobserved prisoner on prisoner assaults. Five such assaults have been recorded on G-wing during the last two and a half years. Brixton has acknowledged that the solution to the problem is to fit lockable doors to restrict access to the shower rooms.

I recommend that the Governor takes steps to reduce the number of assaults and the potential for incidents of self-harm occurring in the shower rooms on G-wing. Preferably, this would entail fitting lockable doors to restrict access.

If the installation of lockable doors is not considered feasible, I recommend, as a minimum, that the overhead pipes in the shower room be boxed in to eliminate this very obvious ligature point.

The pipe in the shower room to which the man tied the ligature is at ceiling height. In order to secure the ligature the man might well have stood upon a chair that the investigators observed when they went to the shower room on their first visit to Brixton. My investigators asked why this chair was needed as the shower room has a fixed bench for prisoners to leave their clothing while showering. My investigators were told that the chair did not belong in the shower room. Instead, officers thought that a prisoner must have brought the chair from one of the resource rooms on G-wing. My investigators asked for the chair to be removed, but when they returned to Brixton a week later the chair was still present. They asked again for the chair to be removed. I am disappointed that this reminder was needed.

During one of the staff interview, the member of staff commented on how busy G-wing was and how busy staff were kept. The investigators felt the same way when they visited G-wing. I am pleased that Brixton has since reconfigured its wings to balance more effectively the pressures and workload.

Other family issues

The man's family were upset with Brixton's family liaison arrangements. The family complained about constant difficulty in contacting the Family Liaison Officer (FLO). They felt that the family liaison system had broken down in their case and this added to their deep distress. The family specifically complained that they waited many weeks for the return of the man's ashes and even longer before they received reimbursement of the funeral director's fees. There was then a further delay before reimbursement of the man's interment fees. It would also seem that the man's belongings have been mislaid. It took Brixton over 18 months to finally confirm that the belongings could not be found and this considerable delay has understandably compounded the family's great upset for the loss of their loved one. The family had particularly hoped for the return of a number of items of chain wear given to the man by his mother by which they could have remembered him.

At the time of the man's death, Brixton's suicide prevention co-ordinator was also Brixton's only FLO. In the former role, the FLO was engaged heavily at the time following the man's death in delivering training to staff in ACCT (the process that has replaced the F2052SH). Like the man's father, my investigator also had recurring difficulty in contacting the FLO. I understand that there are now two other trained FLOs at Brixton. I welcome the fact that Brixton now has an FLO team. Family liaison is an important task and those assigned to it must have had sufficient training as well as having ample time and support from prison management to allow them to perform effectively. Prison Service Order 2710 gives detailed advice and guidance about this extremely important role.

I recommend that the Governor ensures that his prison adheres to the principles set out in Prison Service Order 2710 relating to selection, training, support and supervision of family liaison officers.

Searches of prisoners and their cells

My investigator was told that strip searches of prisoners combined with searches of their cells occur routinely. The selection of a particular cell is usually a random process. The exception is where the prison receives information that a prisoner might be in possession of unauthorised articles. Brixton's security department holds no record of the man ever having been subject to such a search. I am not able, therefore, to say anything definitive about this matter.

Recognition of the man's risk of suicide/self-harm

As has been mentioned, this investigation has revealed a number of missed opportunities to have better assessed the man's potential risk of suicide. These missed opportunities include the failure to obtain the man's community clinical records, the breakdown in his referral to the psychiatric outreach team and the seeming failure by anyone at the prison to read the letter from the manager from the Spitalfields Crypt Trust.

However, it is a matter of speculation what might have happened if the community records had been obtained and if the psychiatric outreach team had assessed the man. What we do know is that the man presented as a seemingly happy person who let out very few signals to suggest he was in danger. He made a remark that led to an F2052SH being opened, but almost immediately afterwards insisted to staff that his words had been misinterpreted. The evidence from staff suggests that the man's behaviour was the same after the form was opened as it had been before.

We know that the man made various remarks to fellow prisoners and even asked one of them to write what was, effectively, a last will and testament. However, none of the prisoners reported these remarks to staff; indeed none of them thought that the man was at immediate risk.

The man had two visitors on the day before his death. Both thought that the man seemed well, including the manager from the rehabilitation unit who knew him from his time at the Spitalfields Crypt Trust (this was not the same manager as the one that wrote the letter). Even on the day of his death, the man was in good humour when he saw the second doctor for a review of his F2052SH. The man then spent the rest of the morning associating with other prisoners and he was last seen alive just minutes before his death when smoking a cigarette with one of his friends who had no suspicions of what the man was about to do.

Another of the prisoners said though the man was acting strangely that morning.

KEY FINDINGS FROM CLINICAL REVIEW

The full clinical review is appended at annex A. Listed below is a summary of the clinical reviewer's main findings:

- There were inaccuracies in the man's records about his past medical history, his clinical diagnoses and present medication.

- There was an inadequate system for obtaining clinical records from community providers.

- The man was referred twice to Brixton's psychiatric outreach team but neither referral reached its destination so no mental health assessment undertaken.

- There was no system for the man to be reviewed by a clinician during the first few weeks after his arrival at Brixton. Such a system would have identified that the man had not had a mental health assessment.

- There was no system to trigger a review when the man ceased taking his medication.

- There was no active involvement by a pharmacist in the management of the man's medication.

- There were surprisingly few significant entries in the man's medical records.

- There was an inadequate system for managing appointments for prisoners attending the GP clinic.

- There was an inadequate system for follow-up of prisoners failing to attend the medical review of their risk of self-harm.

- The residential unit manager who saw the man for initial consideration of the F2052SH form had had no training in mental health nor in assessing risk of self-harm.

- The GP's review with the man of his self-harm risk was conducted in an unsatisfactory environment and without reference to his medical records. Although the GP carried out a thorough assessment, he failed to make an adequate record on the F2052SH form.

- A letter from the Spitalfields Crypt Trust with warnings about the man's risk of suicide was filed in his records with seemingly no attention paid to its contents.

- Staff generally followed correct procedures when trying to resuscitate the man but there were some deficiencies such as the ratio of rescue breaths to chest compressions.

- There was no significant event analysis to review the man's care and treatment following his death.

- The managerial control of systems in healthcare was found to be poor.

- The nurse should be commended for her quick response when the Code One emergency was raised.

RECOMMENDATIONS

My report makes three recommendations and I endorse all 19 recommendations made in the clinical review. The Prison Service has responded to the majority of the recommendations and the responses are inserted in italics following each recommendation. The Prison Service has not provided responses however to recommendations one, three, four and eleven.

1. I recommend that the Governor issue renewed guidance to staff about challenging and dealing with prisoners who obscure their cell door observation flaps.

   No response received from Prison Service.

2. The Governor should take steps to reduce the number of assaults and the potential for incidents of self-harm occurring in the shower rooms on G-wing. Preferably, this would entail fitting lockable doors to restrict access.

   Response from Prison Service: recommendation partially accepted. The new Violence reduction strategy has been published which will help to reduce assaults and ensure that incidents are investigated. A survey of all recesses has been commissioned to look at the feasibility of locking off these areas however the showers are used during association periods and have limited supervision. Target for completion: March 2008.

3. If the installation of lockable doors is not considered feasible, I recommend, as a minimum, that the overhead pipes in the shower room be boxed in to eliminate this very obvious ligature point.

   No response received from Prison Service.

4. I recommend that the Governor ensures that his prison adheres to the principles set out in Prison Service Order 2710 relating to selection, training, support and supervision of family liaison officers.

   No response received from Prison Service.

The clinical reviewer made 19 recommendations in his clinical review. Some of these are for consideration at a local level. Others are for consideration at a national level. The recommendations in full are contained in the annexed clinical review, but they are summarised below:

5. There should be a system for recording the receipt and agreed action for all documents and papers for prisoners.

   Response from Prison Service: recommendation accepted. HMP Brixton does attempt to acknowledge and record all records and information that arrives with the prisoner at reception and a reminder will go out to staff regarding this. Action completed.

Nationally PSO 0500 makes it mandatory for all establishments to have in operation a local protocol to ensure that reception staff act on information received, and that there is efficient transfer of information/documentation. Currently there is no mention in this PSO of what to do with a letter, in the prisoners possession that alerts staff to a risk of suicide. This will now be added to the table on information flows that appears in PSO 0500.

6. When new prisoners are seen by the doctor on arrival in Brixton all relevant documents (such as FME reports) should be present.

Response from Prison Service: recommendation accepted. This is now listed as an action for nurses working within reception. There will be ongoing review of this to further improve information available to doctors. Action completed.

7. Healthcare management at Brixton should consider the possibility of developing the system of assessment for newly arrived prisoners to ensure more complete, accurate and thorough early assessments. One such approach might be as follows:

a. Limit the First Reception Health Screen (FRHS) to the identification of immediate needs.

Response from Prison Service: recommendation accepted locally. On going discussions with clinical leads within Brixton and the London wide offender health team as any changes to the reception screen needs wider agreement. Target for completion: end of January 2008.

b. The following morning make urgent contact with the prisoner's GP and obtain a brief, faxed, summary of past medical history and medication.

Response from Prison Service: recommendation accepted locally. Staff information notice circulated to ensure that we attempt this. Action completed.

c. Later on during the day following admission, a fuller and more comprehensive assessment of the prisoner to take place with the prison GP.

Response from Prison Service: recommendation partially accepted locally. Discussions between healthcare and Deputy Governor have been ongoing. Further discussion needed with the wider prison regime and managers. Target for completion: February 2008.

d. A review date to be set, usually not longer than two weeks later for any prisoner with health problems or on medication, when they could be reviewed by a doctor in the light of fuller GP records. This review to include an agreed decision for the date of the next clinical review by a doctor or nurse.

Response from Prison Service: recommendation accepted locally. This has been a target for healthcare and will be further discussed with EMIS leads from the PCT. Whilst this happens with some patients it is not yet an automatic process. Target for completion: March 2008.

8. A robust and effective system should be instituted to enable the medical records of all new prisoners to be obtained from the most recent GP that the prisoner was registered with.

   Response from Prison Service: recommendation accepted locally. Discussions with healthcare and the appropriate representatives from the local PCT have been agreed to resolve this issue. Target for completion: April 2008.

9. A system should be instituted for healthcare staff to review newly arrived GP records for all new prisoners. The system should include the identification of any significant discrepancies between the history given by the prisoner on arrival and the clinical details in the medical records.

   Response from Prison Service: recommendation accepted locally. This is the responsibility of the primary care manager and is subject to review of the effectiveness of the current system. Action completed.

10. The system for reviewing the treatment and management of new prisoners by the end of their second week in prison should include the involvement of a member of the pharmacy team.

    Response from Prison Service: recommendation partially accepted locally. This is to be judged on a case by case basis. HMP Brixton is looking at good practice guidance and measuring its application within a prison environment. Target for completion: March 2008.

11. Systems must be in place at Brixton to ensure that the clinical records of a prisoner are always easily available to any member of healthcare who sees and assesses a prisoner.

    No response received from Prison Service.

12. Consideration should be given to the development of an information-sharing protocol to cover:

    a. Sharing clinical information between primary care, mental health and substance misuse teams;

       Response from Prison Service: recommendation accepted locally. Written protocols between healthcare staff now in place with regular review at multi disciplinary meetings. Action completed.

    b. Sharing clinical information between healthcare and discipline staff;

       Response from Prison Service: recommendation accepted locally. This is being discussed and will be written following draft and comments. Target for completion: April 2008.

    c, Standards and expectations of record-keeping;

       Response from Prison Service: recommendation accepted locally. Currently in draft and for sign off. Target for completion: February 2008.

d. Records of healthcare review appointments; procedures for obtaining consent to access prisoners' own GP records and then obtaining those records.

Response from Prison Service: recommendation accepted locally. Being drafted. Target for completion: April 2008.

13. The system for arranging appointments for prisoners to be seen by the GP or another clinician, including the arrangements for prisoners on self-harm review procedures, should be urgently looked at and improved.

Response from Prison Service: recommendation accepted locally. This has been reviewed on a regular basis and will continue to be so. Healthcare staff now a much more integral part of the ACCT reviews and proactive in arranging appointments with appropriate services. Action completed.

14. Formal assessments of the mental state or risk of self-harm and suicide of any prisoner should only be carried out by a member of staff who has had adequate training and experience to carry out such an assessment.

Response from Prison Service: recommendation accepted locally. Healthcare ensure this for healthcare employees and are an active part of the training programmes for ACCT assessors. Additional support and further training has been given through external mental health organisations and this will increase. Action completed.

15. Formal assessments of the mental state or risk of self-harm and suicide of any prisoner must always include a minimum level of contact and discussion with members of the healthcare team.

Response from Prison Service: recommendation accepted locally. A training package has been agreed for wing based nurses and more integrated multi disciplinary working in evidence. Wing nurses aware of those on open ACCT forms. For review in May 2008.

16. Formal assessments of the mental state or risk of self-harm and suicide of any prisoner should be undertaken in an appropriate environment.

Response from Prison Service: recommendation accepted locally. All attempts are made to ensure assessments carried out in appropriate environments however emergency assessments are at times needed although the environment is always a consideration and as such is recorded. Action completed.

17. All clinical contacts between the healthcare team and a prisoner should be documented appropriately in the clinical records.

Response from Prison Service: recommendation accepted locally. This is subject to regular review. Action completed.

18. Documentation of self-harm and suicide risk assessments (now ACCT) should always be completed as required on the form.

Response from Prison Service: recommendation accepted locally. Nurses now record in open ACCT documentation and not only clinical records. Action completed.

19. The training needs of all discipline staff should be reviewed, and must include up-to-date training in cardiopulmonary resuscitation (CPR). Senior discipline staff who may be required to make decisions in relation to suicide and self-harm risk, must have regular and up-to-date training in suicide prevention and appropriate mental health issues. Ideally there should be increased training in suicide prevention for all discipline staff.

    Response from Prison Service: recommendation accepted locally. This is being tackled through the primary care mental health stream which has been awarded funds via the Sainsbury Centre for Mental Health for this purpose. The programme will begin in Feb 2008 at the earliest.

20. Healthcare management must institute effective systems to monitor and ensure compliance with agreed processes and procedures.

    Response from Prison Service: recommendation accepted locally. Being reviewed through clinical governance. Monitoring is ongoing.

21. Healthcare management should institute a system to monitor the progress of internal and external referrals such as to the Outreach Mental Health Team.

    Response from Prison Service: recommendation accepted locally. In place and also monitored by the London Offender Health Team. Action completed.

22. A process of significant event analysis (SEA) must be introduced for all major incidents such as deaths or attempted resuscitation.

    Response from Prison Service: recommendation accepted locally. Agreed between the major stakeholders and to be further discussed for implementation. Target date for completion: March 2008.

23. Consideration should be given to developing a process of identifying prisoners who may be at particularly high risk of suicide as soon as they enter Brixton. There should then be a system to offer these prisoners frequent contacts with appropriately trained members of staff.

    Response from Prison Service: recommendation accepted locally. Discussions are on going and will be supported by the primary care mental health bid for training and awareness. Target for completion: February 2008.