Circumstances surrounding the death of a man at HMP Brixton in September 2007

Report by the Prisons and Probation Ombudsman for England and Wales

October 2009

This is a report into the apparently self-inflicted death of a man at HMP Brixton on 5 September 2008. He was found hanging in his cell on a residential wing, following his discharge from the healthcare centre less than 24 hours before.

I must apologise to the man's family for the delay in producing this report. I also express my sincerest sympathy for the loss of their son and brother. I trust that this report will go some way to answering the questions that they have.

The investigation was carried out by one of my investigators on my behalf. I am grateful to the Governor of Brixton for the support that he personally gave this investigation. I must also thank his staff for their co-operation.

In November 2007, Lambeth Primary Care Trust (PCT) commissioned a review of five deaths in custody, including this man's death. The resulting report was not specific enough to this investigation. I thank them for agreeing to rework their original contribution and have included a revised draft of the clinical review at the first annex of this report. However, the time taken to complete the review has considerably delayed the report and regrettably some clinical matters remain unresolved.

The man lived with his family in the Brixton area of London. He had been in prison before and this was his second time at Brixton. Diagnosed with paranoid schizophrenia, the man was waiting for a referral to a secure mental health setting. He was subject to suicide prevention measures until the week before he died. The day before he was found, he was discharged from the healthcare setting and located with a highly disordered prisoner. The man was found at around 9.45am on 5 September. Although his exact time of death cannot be determined, it is likely that he died some hours before he was discovered.

My investigation examines the man's treatment in the healthcare centre and the decision to discharge him from the wing, and the proximity of that decision to the decision to stop suicide prevention measures. My investigation sets out the events of the morning of 5 September. I make five recommendations.

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

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SUMMARY

The man was born in Ecuador and moved to the United Kingdom when he was 14 years old. Initially, he adjusted well to life in a new country and swiftly learned the language. However, by the time he was 17 years old, he was using cannabis and began to develop visual and auditory hallucinations. He was taken into a young offenders' institution (YOI) for the first time in 2004. In early 2006 he was an inpatient at a community mental health unit in Lambeth for three months. He continued to offend and he was eventually remanded to his second period of custody in May 2007. Mistakenly, he was taken to Feltham YOI, (he was 22 at the time and too old for a YOI).

When he arrived at Feltham, the man was unhappy to be in a YOI, because he was older than the other prisoners. He was admitted to the healthcare wing for treatment of his mental health problems and settled well. He was subject to suicide prevention measures. On 17 July, the man appeared in court. He was proven to be 22 years' old and had to be moved to the adult male prison estate. The judge also required two psychiatric reports, to determine the man's mental health and to assess his dangerousness in the community, so that he could sentence accordingly. The date of the next court hearing was set at 11 September, pending the psychiatric reports.

The man was admitted to the healthcare centre as soon as he arrived at Brixton. The consultant psychiatrist had been contacted by the psychiatrist at Feltham to notify him in advance that the man would need treatment for his mental health. The man shared a cell in the healthcare centre for the duration of his time there. He mixed well with other prisoners, but was described by staff as quiet. Suicide prevention measures remained open. Occasionally the man made reference to thoughts of self harm, but he was preoccupied by the continued visual and auditory hallucinations he experienced as part of his psychosis, (which had been diagnosed as paranoid schizophrenia). Staff noticed that the man settled down well, although he repeatedly asked when he was going to be transferred to a mental health hospital for treatment.

On 29 August, the man's final suicide prevention case review was held. He attended and told the two nurses present that he did not feel at risk of self harm. The nurses agreed that his risk had reduced and closed the suicide prevention document. Two days later, the consultant psychiatrist spoke to the man about the possibility of discharging him from the healthcare to a residential wing. During this discussion, the man reassured the psychiatrist that he had no ongoing thoughts of self harm or suicide. He also asked whether he would be transferred to a mental health setting and the psychiatrist reassured him that he would, but it was likely to be a non-urgent transfer so might take some weeks. The decision was reached to discharge the man the following Monday, 4 September.

A nurse completed the medical liaison form as part of the healthcare discharge policy. She did not write any information on the form that she considered to be medical in confidence. Therefore, there was no indication that the man had mental health problems, his diagnosis or any details of the medication that he

was taking. The form noted that the man was not subject to “current” suicide prevention measures, but made no mention of the recently closed document. While being escorted to the wing on the Monday afternoon, the man told the officer that he thought he was no longer going to a mental health secure setting for treatment if he was being discharged from the healthcare centre. He was upset. Upon arrival at the wing, the man was located with an extremely disordered prisoner. There is no record of whether his prescription chart or medication were transferred to the treatment room on the wing.

The following morning, the officer on the night shift carried out a roll count at around 6.00am. He was alone while performing this roll count and had to carry out observations on prisoners who had been identified as at risk of self harm at the same time. The officer said that it was light enough in the cell to see where the prisoners were. It is unlikely that he looked into the man’s cell. The morning staff were unclear about whether they needed to carry out their own roll count, especially as they did not sign for the number of prisoners in their custody. The regime was affected by extraordinary staff shortage that morning. Prisoners were not unlocked from their cells until 9.45am. The officer who opened the man’s cell did not look into the cell because he felt harassed by prisoners as he was walking up the landing. Prisoners on the landing first saw the man hanging from his window at the back of his cell and alerted staff.

Staff attended the cell. It is likely that the man had been dead for some time. Resuscitation was attempted, nonetheless. Healthcare staff arrived and applied the defibrillator. It instructed not to shock. The doctor arrived at the cell and pronounced him dead at 10.26am.

THE INVESTIGATION PROCESS

1. My investigator visited HMP Brixton to open the investigation. She was introduced to the Governor and representatives from the Prison Officers' Association and the Independent Monitoring Board. She met the liaison officer for the investigation, the Head of the Secretariat. My investigator was shown around the prison, including the reception area, the healthcare centre and A Wing. She spoke with the Head of Healthcare who explained the brief circumstances surrounding the man's care in the healthcare centre and the decision to discharge him. My investigator collected the files that were available.

2. At the time of the man's death, Lambeth PCT was in the process of appointing a clinical review team to conduct several outstanding clinical reviews for the prison as one joint exercise. The investigator provided the PCT with a list of the clinical issues. The investigator also requested that a member of the clinical review team would conduct joint interviews with her during the investigation. The clinical review team conducted their review in isolation from my investigator and provided a document which outlined a brief chronology of the man's care, but did not make any specific recommendations. Instead, they provided a list of general recommendations, of matters which arose from all of the outstanding clinical reviews. I am grateful to Lambeth PCT for responding to my investigator's concerns and the clinical review team for providing a revised clinical review with specific recommendations in July 2008. However, the revised report still falls short of dealing with all of the clinical matters raised by my investigator at the beginning of the clinical review process. In order to avoid further delay, I have proceeded with this investigation. The clinical review is the first annex to this report.

3. The investigator issued notices inviting staff and prisoners to contact her with any information they felt might be relevant to the investigation. There was no response to these notices. The investigator arranged a meeting with the man's cellmate in the weeks following his death, in order that she could speak to him before his release. She went on to conduct interviews with staff throughout October, November, December, January and April. She used police statements for other prisoners involved in the events of 5 September.

4. One of my Family Liaison Officers contacted the man's family to offer them the opportunity to be involved with the investigation process and to raise any relevant issues and concerns they had. She was accompanied by the investigator for two meetings with the family, the first without legal representation and the second with their solicitor present. These meetings were very helpful to the investigation process and I am entirely grateful to the family for their time. I hope the investigation goes some way to answering the questions that they have about the man's care.

HMP BRIXTON

5. Brixton is an adult male local prison, which can accommodate up to 798 prisoners. Like all London local prisons, Brixton's population is ever-changing and is always close to the operational capacity. The prison is made up of four wings, A, B, C and D wing. A wing is the main wing of the prison and accommodates 264 prisoners in 143 cells, all but one shared accommodation.

6. In her most recent inspection, Her Majesty's Chief Inspector of Prisons found that a positive culture had developed since her last inspection, two years previously. The violence reduction strategy encompassed an effective anti-bullying scheme and prisoners were out of their cells for longer than they had seen in other public sector prisons.

7. D wing is the inpatients' healthcare centre. The man spent almost all of his time at Brixton on D-wing. The Chief Inspector was particularly critical of the healthcare centre, which was originally built as a temporary measure to be used for a six month period. My investigator agreed that the physical environment was not fit for accommodating prisoners with primary care or mental health needs. The Chief Inspector found that there was too much reliance on agency nurses and that the lack of uniform led to some confusion about staff's role among the prisoners.

8. Since April 2008, the healthcare provider has changed following a tendering process. I hope that the lessons from this investigation have been taken into account when designing the new healthcare regime. The Governor also informed my investigator that the plans for a new healthcare centre have been approved and it is scheduled to be built in the next few years.

9. The Independent Monitoring Board (IMB), in their annual report, acknowledges that the healthcare centre focuses on prisoners with acute mental health needs. The IMB is an independent organisation made up of volunteers who monitor daily life in a prison and ensure that proper standards of care and decency are met.) The IMB found that, "the prison's healthcare wing is not sufficiently well-resourced to offer these prisoners appropriate care of treatment". The report went on to echo the aforementioned concerns about the healthcare centre's physical environment, suggesting it would "fall far below the public's expectation of humane conditions and can only serve to aggravate the situation of these vulnerable people".

10. The man's death was one of four deaths at Brixton in 2007, one of which was death by natural causes. My investigator has taken into account the findings of these other investigations, but has found no significant shared lessons between the reports.

KEY EVENTS

11. The man was remanded to HM YOI Feltham on 15 May 2007. He was charged with robbery. His date of birth was recorded in error and staff thought he was 21 years old. In fact, the man was 22 and his date of birth had been mistaken. Feltham is a young offenders' institution, designed to accommodate males between the ages of 15 and 21 years old. Upon his arrival, he told a senior officer that he was unhappy to be at Feltham because of his age.

12. The man was admitted straight to the inpatients unit, known as Lapwing, where he was referred for a mental health assessment. He had been to Feltham before and they recognised him as someone who would need input for his mental health needs. Also, the man had cut his throat with a plastic knife the day before he was remanded to Feltham. The man told staff that he could hear a male voice telling him that he could not have children and a female voice telling him that prostitution is bad. He said that he smoked cannabis and drank a quarter of a bottle of whisky a day. He was also taking antipsychotic medication.

13. The following day a mental health assessment was completed. It was recorded that the man had been an inpatient at Lambeth Hospital, treated for his mental health problems and he was on Aripiprazole, an antipsychotic drug. He told a nurse about the offence that he was charged with. He said that he had robbed someone so that he could give the money to a prostitute and help them stop prostitution. He went on to say that while he had always experienced hallucinations, they had not been particularly troubling until around two and a half weeks before he came into custody.

14. Shortly after the mental health assessment, a memorandum arrived at Feltham sent by the man's community mental health worker. She wrote that it had been difficult to monitor the man's situation in recent weeks because he had such a chaotic lifestyle. She thought it unlikely that he had been taking medication since he had moved out of his mother's house. She asked to be kept informed of how the man was doing in prison and the progress of his court case. The prison nurse contacted the community mental health worker and discussed how the man was while he was in the community.

15. Throughout his time on Lapwing, the man was subject to suicide prevention measures, known as 'Assessment, Care in Custody and Teamwork' or ACCT. Staff had identified him being at risk of suicide or self-harm due to his mental state. To begin with, the man was checked at least five times an hour and staff kept an ongoing record of significant events, conversations and observations.

16. On 17 May, the man spent the night banging his head against the wall and apparently answering the male and female voices that he could hear. A note was made on his ACCT ongoing record that he was "extremely distressed" during the night but that he appeared more calm after he was given his medication.

17. The man's ACCT Caremap was drawn up on 18 May and described him as "a risk to himself due to his mental state". With that risk in mind, it was decided that

he should remain in Lapwing, where he could have regular one to one sessions with staff and was encouraged to take part in activities. The man told staff that he thought he benefited from his time in a mental health hospital in 2006 and thought that it might help him to go to a hospital again. He said that he felt "a little reassured that staff are monitoring via the ACCT document". At the time he was being observed at least five times an hour.

18. The man settled into life on the Lapwing Unit. He told staff that he would watch television as a means of distraction and that he would try to occupy himself. He mixed well with other prisoners, telling them about his life in Ecuador. He went to church every Sunday and participated in group activities, such as current affair discussions and art therapy. He came second in a cell-cleaning competition.

19. On 4 June, the man's mother and sister spoke to a Consultant Psychiatrist. He told them that there had been an improvement in the man's mental health since his previous sentence at Feltham. The frequency of the man's ACCT observations was reduced. Staff were instructed to make three significant entries in his ACCT record per shift. The man's mother agreed to send in a copy of his driving licence to verify his age. Three days later, he was told that he was likely to be transferred to an adult prison and he was "not keen". He told staff that he had been bullied when he was in Brixton before and he was worried about it.

20. The man spent the rest of his time at Feltham engaging well with group activities and getting on with life on the wing. He said that he could still hear voices and asked for an increase in his medication. He expressed concerns about his immigration status and officers said that they would contact "relevant agencies". He thought he was going to be deported because he had been in prison so many times. As the man's court case approached, he became more anxious about his immigration status. He left a class early because he was worried about his court appearance, although he told staff that he was ready to plead guilty for his offence.

21. During a dramatherapy group on 13 July, the man was described as "preoccupied with his transfer to Brixton, said it was a stressful thing to think about but that he just wanted to do his time". He understood that he was likely to be transferred to Brixton after his court appearance. The consultant psychiatrist at Feltham emailed a psychiatrist at Brixton on 16 July, to brief him about the man's mental health condition. He described how the man's original prescription of Amilsupride had been changed to Risperidone because he had reported that the previous medication had stopped him from sleeping. He said that there was a plan to give the man a six week trial of a maximum dose antipsychotic because the man still experienced hallucinations. The psychiatrist at Feltham also rang the man's solicitor to inform him that Brixton had been briefed about the man's possible transfer there and his mental health state. He discussed the man's anxiety about his immigration status and the fact that he thought that he might receive a long sentence, although he thought that he was "happy" about his transfer to Brixton.

22. The man appeared in court on 17 July and pleaded guilty to the offence of robbery. His solicitor advised my investigator that the man was due to be assessed under the 'dangerousness provision' of the Criminal Justice Act 2003 before sentencing. He faced a likely sentence of approximately five years if he was not assessed as 'dangerous', under the terms of the Act. In the solicitor's opinion, given the circumstances of his offence and his offending history, the man was likely to be assessed as dangerous and receive an indeterminate sentence for public protection, a form of life sentence. In order to determine whether the man was 'dangerous' and to ascertain the extent of his mental health problems, the sentencing judge required two psychiatric reports to be prepared for 11 September. The man was made aware of the possible sentences that he was facing at the time of his court appearance. In respect of his immigration status, his family told the court that he had been granted indefinite leave to remain in the UK. The solicitor advised my investigator that there was a strong human rights argument for him not to be deported due to the ongoing treatment for his mental health. Therefore, it was unlikely that the man would be deported.

23. After the court appearance, the man was taken to Brixton. A cell sharing risk assessment was completed, in accordance with prison procedure when a prisoner arrives for the first time at a prison. The form acknowledged that the man had been on Lapwing at Feltham, he was on an open ACCT and found that there were no concerns with him sharing a cell. He told staff that he was fine and that he wanted to be located on the healthcare centre. Following the advice from Feltham that he was suffering from mental health problems, the man was located on the healthcare wing at Brixton and his ACCT document remained open, requiring three significant entries per shift. The psychiatrist at Brixton emailed the psychiatrist at Feltham to confirm that the man had arrived. The man did not undergo an induction.

24. It was not possible to determine what medication the man was prescribed throughout his time at Brixton because the prescription charts could not be found after his death. However, the man was on Risperidone when he arrived at Brixton, there is no clinical note to suggest that his medication changed in his inmate medical record and he was on Risperidone when he attended a clinic with the psychiatrist at Brixton on 31 August. It is likely that the man remained on Risperidone throughout his time at Brixton.

25. A nurse interviewed by the investigation team explained that prisoners on the healthcare wing collect their medication from the treatment hatch, located on the ground floor of the wing. Prisoners collect it from the time that their cell is unlocked in the morning at around 8.30am until the end of the exercise period at 10.00am. If prisoners do not collect their medication, staff call to the prisoner to ask them to collect their medication before the treatment room closes. If the prisoner refuses to take his medication, staff speak to him to find out if there is a problem. A prisoner can refuse to take their medication on the healthcare wing, much as they can in the community, and a note is made on the prescription chart. If a prisoner cannot get to the treatment room for medical reasons, the medication will be brought to their cell. This process is repeated at lunchtime,

dinner time and in the evening. All staff remembered that the man would collect his medication at the appropriate time.

26. An ACCT Case Review was held two days after the man arrived at Brixton. He was described as compliant with prescribed treatment and the wing's daily regime. The ACCT remained open because the man still reported hearing voices. The man remained subject to observations, with at least three significant entries per shift. A Specialist Registrar working in Brixton made the following entry in the man's clinical record:

> "Currently has some passive suicidal ideation when thinks about upcoming sentencing but no current intent or plans to self-harm or attempt suicide."

('Passive suicidal ideation' means that there is a desire to die but without a specific plan.)

27. The man's nursing care plan was completed on 20 July, aimed at stabilising his mental state by encouraging him to attend visits with his family, attend occupational therapy groups and attend to his personal hygeine. A psychiatric assessment, completed the same day, noted that there was no evidence of hallucinations and he was co-operating with the wing regime. His history of self-harm was noted. Later that day, the man told staff at an ACCT case review that he had self-harmed and showed them scratches on his arms. He said that he could not handle being in prison. Following the review a senior nurse examined the man and remembered that the scratches on his arms were not recent. However, the record of the review noted that the man "may self harm if he is given a prison sentence".

28. By 22 July, in contrast with his behaviour at Feltham, the man had to be prompted to clean his cell and look after his personal hygiene. During his time on the healthcare wing, he complained of hearing voices, although staff saw no evidence of this. At an ACCT case review, the man told staff present that he had self-harmed. Although the senior nurse was not available for that ACCT meeting, during interview she recalled looking at the marks that the man claimed were self-inflicted. She described them as superficial scratches that had been made some time ago. In her view, the man had not self-harmed recently, as he claimed. The ACCT remained open with at least three significant observations .

29. On one occasion, 29 July, the man said that he heard "voices (male and female) telling him that he will be raped if he goes to ordinary location". Throughout this time, he was compliant with his medication but he complained it was not helping him sleep.

30. On 1 August, a note was made in the man's ACCT record that he "appeared settled". In the following days, staff noticed he was out of his cell watching television in the healthcare centre communcal area. He "interacted well" with staff and other prisoners. He went to exercise and an occupational therapy group on 7 August. He continued to mix with other prisoners on the wing and was noted having conversations with his cellmate.

31. Towards the end of August, staff observed that the man began to look after his personal hygeine again. He continued to mix with other prisoners on the healthcare centre, although he was described as “quiet”. The man was observed to be “low in mood” and “reluctant to come out of his cell”, on 20 August. However, the following day, one of the nurses noted that the man was “eating and drinking quite well – no evidence of self harm observed”. On 24 August, the senior nurse wrote the following in his ACCT record, “appears comfortable, due for review, has not self-harmed for a long while”. The man attended church on 26 August.

32. In a weekly nursing summary on 28 August, one of the nurses noted that the man’s ACCT document had been opened since 15 May and that his court date was scheduled for 11 September. The summary recorded that the man had been appropriate in his behaviour and that there had been no evidence of hallucination. He had cleaned his cell earlier that day and was observed associating well with other prisoners.

33. The following day, the same nurse took part in an ACCT case review with one other nurse and the man present. He told the nurses that he was still hearing voices but said that he no longer wanted to be on the ACCT document. He said that he was just waiting for his psychiatric report so that he could go to hospital. By that, the man meant the second psychiatric report required by sentencing judge, becase the first report had already been submitted to his solicitor. The second report was to be completed by the psychiatrist. One of the nurses explained that, even if he was to go to hospital, the man would still have to serve the remainder of his sentence when he was discharged. During interview, the nurse said that the man was aware that he would have to serve the remainder of his sentence but he felt that he needed to remind him because he was so focussed on the hospital admission.

34. The nurses decided to close the ACCT document during this case review. One of the nurses told my investigator that he wanted to see how the man got on without being on the ACCT document. He thought that he had become less withdrawn and had noticed an improvement in his association with staff and prisoners. However, he added that he thought that he would be on the healthcare centre until the post-closure review, scheduled for 15 September, and therefore would be closely monitored by healthcare staff. If it was felt that his ACCT document needed to be opened again, the nurse was confident that healthcare staff would revisit the decision to close the document. He said that because the man was “happy” for it be be closed and they thought that he had no intent to self-harm at that time. The nurse knew that the man’s sentencing date was coming up but believed that he would be going to a mental health secure unit and so would not be anxious about this date.

35. On 31 August, the psychiatrist completed a healthcare wing review. During interview, the psychiatrist explained that he has a clinic every Friday afternoon and will see between five and six prisoners. Who is seen during that session is determined by conversations with staff and his own observation but he sees all of the prisoners regularly at this session. A healthcare wing review is completed

in a private room in the healthcare centre, with the psychiatrist and a nurse present. The psychiatrist speaks to the prisoner for between five and forty five minutes, depending on the prisoner's need. During the man's review on 31 August, the psychiatrist found that the man's presentation had not changed and that he had no thoughts of deliberate self harm or suicide at the time of the review. The psychiatrist concluded that the man should remain on the healthcare wing over the weekend and should try ordinary location early the following week. He told my investigator that a number of healthcare staff had suggested to him that the man was ready to be discharged to a residential wing. He said that these conversations took place in the nursing station and did not name specific members staff. He thought that the man might benefit from the increased activity of the residential setting and he was concerned about the difficult atmosphere of the healthcare wing, with such a high number of prisoners with mental health needs. He made a note that the man would need to be referred to the mental health outreach team because he would need regular follow-ups. He understood that it was likely that he would go to the residential wing and did not seem concerned about this move.

36. The psychiatrist remembered that the man's primary concern was his admittance to a mental health secure unit. During the review, he noted that the man was being considered for section to Bridge House for treatment. The psychiatrist said that he had been approached to produce a psychiatric report for the court as to the man's mental health condition. Another psychiatrist had also been approached to provide a psychiatric report because two such reports are required when considering a prisoner's dangerousness for sentencing. The psychiatrist explained to the man that he had not prepared the report yet, so he could not be completely sure as to his recommendation, but he thought it was likely that he would recommend a non-urgent referral to hospital, either for assessment or treatment. He explained to the man that such a referral can take a matter of weeks, so he would return to prison after his court appearance, even if a hospital order was made.

37. Over the weekend, the man did not express any concerns about going to the residential wing. He attended the church service as usual. Staff had no concerns about his behaviour.

38. On 4 September, the senior nurse started her shift at about 1.30pm. She remembered that the man was standing around the healthcare office when she came on duty and she asked him if there was anything wrong. He told her that he had a dream about his girlfriend and he was worried about their relationship. She said that prisoners often worry about relationships because they have too much time to think about it, so she gave him a job to do, folding envelopes, which he took to his room. She said that she mentioned to him that he was about to be discharged and he seemed to know about it and did not seem too concerned. The senior nurse took that opportunity to fill in the man's 'Medical Liaison Form'.

39. A Medical Liaison Form is in two parts. The first part goes to officers on a residential wing and has general information about the reasons for admission to healthcare, the prisoner's behaviour in healthcare, whether they have been on

an ACCT document and if they have been referred to external services. The other part of the form goes to wing treatment staff, nurses based on the wing, and has information about a prisoner's diagnosis and medication. The senior nurse noted that the man had been compliant in his behaviour on the healthcare wing and that he was not on an ACCT form at the time of discharge. (The ACCT had been closed five days previously, but this was not mentioned on the form.) No information about the man's diagnosis, medication or further medical instruction were included on this form.

40. The man was escorted by an officer from the healthcare centre to A wing, the largest residential wing at Brixton, at about 2.15pm that day. The officer was not a medically trained member of healthcare staff, although he does work on the healthcare centre. As a non-medical member of staff, the senior nurse told my investigator that the officer could not take the man's prescription chart and medication with him to the wing, because that information is 'medical in confidence'. Instead, the senior nurse asked staff in the healthcare pharmacy to take the medication over to the A wing treatment room.

41. One of the nurses who closed the man's ACCT was working in the treatment room on A wing on the afternoon of 4 September. He does not normally work on the wings but was covering for another member of staff. The nurse told my investigator that he would have remembered seeing the man that afternoon. He said that he did not see him. He said that he did not remember receiving the man's Medical Liaison form or his prescription chart. My investigator was told that it was usual practice for a nurse to call the treatment room on the healthcare centre if a prisoner who knew to be receiving medication had not come with their medication, to see where the medication was. From the evidence available, it is not possible to determine whether the man's prescription charts and medication were transferred to the wing.

42. When a prisoner arrives on the wing, they are located in what is described as a 'holding cell', until they can be allocated the cell which they will live in. The man was brought over to the wing by the officer. The officer remembered that the wing was very busy when he brought the man over. He said that he left him in the holding cell and passed staff the medical liaison form. On the wall of the staff office, there is a board with details of which prisoner is in which cell and any available cells. There was a spare bed in cell A2-30. At the time of the allocation, staff on the wing were not aware of the man's recent ACCT document or that he had significant mental health problems.

43. The man was asked to report to the officer on the second landing who would take him to his cell. The officer based in the wing office (known as the desk officer) rang the second landing to tell them where to take the man, cell A2-30, based on which cells were available. The second landing officer took the call and escorted the man to his cell. The prisoner who he was to share with was suffering from severe alcoholic dementia. He was described by staff as a confused man with some hygiene issues, but was not assessed as a risk to others and was therefore suitable to share a cell. When he got to the cell, the man asked the second landing officer if he could be located with a different prisoner because he did not want to share with this man. The officer explained

that the wing was very full and asked the man if he would mind staying with that prisoner for one night, and they would review the situation in the morning. The man agreed and entered the cell. The second landing officer said that he saw the man a few times that evening and he seemed to be fine.

44. The man made a phone call to his mother after he arrived on A-wing. He asked her to visit him because he was finding it difficult at Brixton. She said that she would try to visit him as soon as she could. (A Spanish chaplain was asked to translate the telephone call following the man's death.)

45. The nurse who closed the man's ACCT explained that when prisoners are unlocked to collect their dinner at around 5pm, they make their own way to the treatment room to collect their medication. He said that the nurse in the treatment room waits until the end of the session and checks all of the prescription charts to see if any prisoner has not collected his medication. Usually, the nurse would ring each landing officer to ask them to remind a prisoner about his medication. The nurse could not remember seeing the man that afternoon, but cannot remember asking landing staff about his non-collection of medication either. He said that if the man had not collected his medication, due to his history and the type of medication he was on, he would have called a landing officer to remind him to collect it.

46. During interview, the psychiatrist explained that Risperidone does not work immediately on the body, but can take a number of weeks to have an effect. He said that a single missed dose of Risperidone is unlikely to impact on someone's psychological state, because there will be enough still in the system from previous doses. Nonetheless, the Head of Healthcare said that he would expect a nurse to follow up immediately with any prisoner who did not collect his dose of Risperidone.

47. There is no evidence that the man's medication was transferred from the healthcare wing to the residential wing. It is not possible to determine whether the man collected his medication that dinner time or not. No member of staff can recall speaking to him about collecting his medication that evening.

48. An officer was due to take over the night shift that evening at 8.00pm. When staff handed over to him, they did not mention the man. The night officer carried out his night time roll check, (when he walks around each landing and counts the number of prisoners to ensure that it matches the number of prisoners by the evening staff who are ending their shift). He said that nine or ten prisoners who were subject to ACCT documents during that shift, one of whom was to be checked every ten minutes. With this in mind, he had been allocated an Operational Support Grade (OSG) to help to carry out his duties. The night officer said that it was a busy night because of all of the checks that he had to carry out. He said that he could not remember seeing the man or the man's cellmate and did not recall responding to a cell bell. The OSG was asked to leave A wing at around 5am, to assist the orderly officer.

49. Night staff must carry out a morning roll check every morning at Brixton, before they go off duty. The night officer explained to my investigator that he visually

counts every prisoner in their cell by looking through the observation panel. He said that if it is dark, he turns the night light on to enable him to see into the cell. Once the roll check is completed, the night officer signs a document to say that the number of prisoners is correct. The night officer signed the morning roll check for 5 September. When asked during interview whether he counted the man, the night officer said that he thought he probably had checked his cell and counted him and his cellmate. He said that he was not absolutely sure because he was checking a prisoner on the bottom landing every ten minutes so his roll check was interrupted. He agreed that it was sufficiently light at that time of year, at 6.00am, that he would have been able to see a prisoner hanging against the window.

50. A reception officer arrived at 6.45am to collect the prisoners that had been woken for court, to take them to reception. Half an hour later, an early shift officer arrived to relieve the night officer of his duties. An officer who comes in for the handover from the night shift at 7.15am is expected to be verbally briefed by the night staff and satisfy himself that the roll check is correct, before the night staff can go off duty. The early shift officer was not clear about whose responsibility this was during interview, but said that he took over the checking those prisoners on ACCT documents. In fact, it is likely that no roll count was done by the morning shift coming on duty on 5 September. In September 2007, there was no requirement for the handover officer to sign anything to say whether the roll count is correct, so it is not possible to determine whether the roll count was carried out from the evidence.

51. A wing was experiencing staff shortage that morning. When the B wing senior officer arrived at work at around 8.30am on 5 September, he was asked to cover A wing's senior officer duties, instead of his usual B wing SO role. He said that he went to B wing to collect a couple of work items and then made his way to A wing. He remembered that there were only two officers on the wing. The B wing SO asked one of the officers to be the desk officer because she was familiar with A wing's regime and immediately alerted the orderly officer to the extraordinary staff shortage on A wing. The B wing SO said that he could not allow prisoners to be unlocked without adequate staffing levels, which would be at least two officers per landing, (there are four landings on A wing).

52. The B wing SO made telephone calls to various prison departments to see if there were officers detailed elsewhere that could be spared for the 'freeflow' part of the day, whereby prisoners are released from their cells to go to work, education or collect medication. A list of prisoners who are due to attend employment elsewhere in the prison or education is given to the wing each morning. On the morning of 5 September, the list was late arriving on the wing. A separate list was given to the wing with all of the prisoners who were due to receive medication. Eventually, just after 9.00am, the B wing SO had received the activity list, but not the medication list. He was satisfied that enough staff were present to unlock those prisoners that had to go to education or work. Two officers arrived on the wing from the visits area to cover and were asked to open the cells on the second landing, where the man was located. The man's cell was not opened because neither he nor his cellmate were due to attend education or employment. Once those prisoners had left the wing, the B wing

SO asked that all prisoners be unlocked for association. At this time, around 9.30am, prisoners who were still on the wing and required medication were expected to go to the treatment hatch themselves. One of the visits officers unlocked the man's cell. The officer remembered being intimidated by prisoners on the wing while unlocking cell doors. Due to the stressful situation, he did not take the time to look in the cell but opened it and went in search of the B wing SO to ask for support with the intimidating prisoners.

53. Prisoners from all four landings were associating on A wing. Three prisoners had arranged a game of backgammon on the landing outside of the man's cell. One of the prisoners told the police that he saw the cell door opened and the man's cellmate sitting on his bed, drinking a cup of tea. Beyond him, he could see the man hanging from the window. He said that he and his companions called for staff to assist. The visits officer had just gone back into the office. The B wing SO recalled being on the landing below and following the visits officer to the cell. They ran to the cell immediately. The visits officer reached the man first. He cut his ligature with an anti-ligature knife from his belt. The ligature was made from a strip of bed sheet. The B wing SO and the visits officer lay the man on the floor. The B wing SO radioed an alarm call, to alert staff that there was an emergency and urgent assistance was required. The visits officer began resuscitation attempts. Officers on the landing appeared at the cell. There were prisoners gathering around the cell, so the B wing SO, with the help of other officers, guided them away from landing into other cells. Two nurses and a doctor arrived within minutes and applied a defibrillator. The instruction was not to shock. A prison doctor attended the cell and at 10.26am pronounced the man dead.

54. The Governor, the prison's appointed Family Liaison Officer and chaplain visited the man's mother later that morning at her home. The police had arrived ahead of them, but had not broken the news. The man's mother was shocked about her son's death and worried that he had been discharged from the healthcare centre without her knowledge. His mother was given a contact number for the prison. His sister arranged to visit the prison and collect his posessions.

The man's family

55. One of my Family Liaison Officers and my investigator met with the man's family at the beginning of the investigation process, to explain the remit of the Ombudsman's investigation and listen to any early concerns. Once the man's family had appointed a legal representative, the FLO and investigator met again with the family and their solicitor for a very helpful meeting, where more concerns were discussed.

56. The man's family were particularly concerned that he was not in a mental health setting, rather than a prison. Contrary to the findings of the clinical review, my investigation cannot comment on why the man was in prison rather than a community mental health setting. However, he received mental health treatment in prison and I will examine the adequacy of that care. The man was also likely to be transferred to a mental health setting as a result of a court hearing on 11 September and my investigation will discuss that process.

57. The man told staff at Feltham that he was worried about being bullied at Brixton. The man's mental health worker during his previous sentence at Brixton was not aware that he felt he was being bullied during that sentence. While he was in the healthcare centre, he was observed interacting well with other prisoners. When he was transferred to the residential wing, he did not mention fears of being bullied to healthcare staff or staff on A wing.

58. One officer alleged to my investigator that the man's cell was repainted before the family visited the cell in the days following his death. This would have misrepresented the situation that the man was in at the time of his death and would be a matter of concern for my investigation. When put to the Governor, he thought it unlikely that this would have happened. There are also no records to support this. I trust that no such adjustment to the man's cell took place and hope that no such practice will ever take place in a prison following a death in custody.

59. The man's family were concerned about the perceived difference in care that he received between Brixton and Feltham. They also asked why, given the much publicised criticism of the healthcare centre at Brixton, the man was transferred there rather than to another male adult prison in London. I will consider these matters further, as far as my remit allows.

60. When the man was at Feltham, he was given nicotine patches, to support him in his attempt to give up smoking. My investigator asked the Head of Healthcare whether he was in receipt of patches at Brixton, but this was not confirmed. No mention is made of the man receiving nicotine patches at Brixton, but neither is mention made of him smoking cigarettes. The Head of Healthcare told my investigator that they do provide nicotine patches for those in need of them.

61. The family were also concerned to learn that the man sometimes slept with his mattress on the floor. There are entries to this effect in his medical record from on 3 and 4 August. None of the healthcare staff that my investigator asked at Brixton recalled him sleeping on the floor on any other occasion. The man settled into the wing during August. No other entries were made in his clinical records, although staff recorded that he was lying on his bed talking to his cellmate on occasions.

62. Other issues raised by the man's family have been incorporated into the body of the report.

Prisoner Support

63. The prisoners on the wing and the man's cellmate were escorted away from the area by B wing SO. The Head of Safer Custody told my investigator that a governor took the man's cellmate to one side and sat with him. She said that he seemed confused and needed someone to sit with him.

64. The other prisoners who had been on the landing were taken to another area of the wing. The Head of Safer Custody explained to them that they would be

spoken to by the police and statements might need to be taken. She also arranged for a Listener to sit with them, in case they needed additional support. (Listeners are prisoners trained by Samaritans to provide confidential emotional support to fellow prisoners in distress.)

Staff Support

65. Most staff told my investigator that they felt well supported after the incident. There was a hot debrief held by the Deputy Governor at the time, which gave staff the opportunity to express their feelings. The officer who found the man had been recently bereaved and had just returned to work at the time. I am pleased to note that he was seen by the staff care and welfare service on 5 September and was supported through a subsequent absence from work.

66. Two members of staff raised serious concerns about the way that they were treated following the man's death. They felt that they received no support from managers. Both officers took a period of stress-related sick leave following the man's death. My investigator brought this matter to the attention of the Governor and the Head of Safer Custody at the time of the investigation and they said that they would look into it further.

ISSUES

Transfer to Brixton

67. The man was transferred to Brixton on 17 July 2007. His mother had provided his driving licence to the court, which proved that he was 22 years old. He was therefore over 21 and had to be transferred to an adult male establishment. Population movement in the Prison Service is managed by a central body called the Population Management Unit. The unit has oversight of all transfers and the number of prisoners in each establishment, however they do not govern specific transfers of named prisoners. Rather, they deal with overall capacity and number of prisoners requiring a custodial placement. Prisoners are allocated to the prison nearest to the court, if there are spaces available. The man appeared at a crown court that was served by Brixton, which is why he was taken there.

68. Anticipating that the man would be transferred to Brixton, the consultant psychiatrist at Feltham emailed the consultant psychiatrist at Brixton to brief him about the man's mental health condition. The consultant psychiatrist at Feltham also contacted the man's solicitor. The man's medical notes were sent to Brixton in advance of his arrival. I am pleased to see such proactive communication, which promotes continuity of care.

69. The man's family were concerned that he was transferred to a prison without adequate healthcare facilities. I will explore his care in the healthcare centre in the following section. However, I cannot accurately compare the treatment that the man received at Brixton to the care that he might have received in another London local prison. As Her Majesty's Chief Inspector of Prisons wrote in her thematic report on mental health:

> "[a]s recognised in mental health legislation, prisons are not primarily therapeutic environments, and the imperatives of security and control will always create a challenging environment for delivering care to the mentally ill".

70. The man was likely to be transferred to a mental health secure setting for treatment. Surely, that is the only place that a young man with his mental health issues can be effectively treated.

The man's time in the healthcare centre

71. The man was admitted straight to the healthcare centre when he arrived at Brixton on 17 July. Prisoners admitted to the healthcare centre at reception forego the induction process. This meant that, despite the man being on an open ACCT document, he did not have an induction, when prisoners are told about how the prison runs and how to access services, such as the Listeners or Samaritans. Prison Service Order (PSO) 0550, Prisoner Induction, acknowledges that there are prisoners who may not be ready for an induction programme as soon as they arrive at the prison because of more pressing healthcare needs. However, it clearly instructs that: "it must be ensured that all

prisoners are given a full induction programme as soon as they are able to benefit from it."

72. The Head of Safer Custody told my investigator that a new induction system has been introduced since the man's death for prisoners who are admitted straight to healthcare. Officers from the induction wing are now notified when a prisoner is admitted straight from reception to the healthcare centre. An induction officer visits the prisoner in the healthcare centre and explains the prison's rules and regime. They will also answer any questions that the prisoner might have. I am pleased that those prisoners who are admitted to the healthcare centre are no longer overlooked in terms of induction, but regret that the man missed this opportunity.

73. The man seemed to settle on the healthcare centre. His mood was described as "up and down" by the senior nurse, but he associated with other prisoners and joined in group activities that were run on the healthcare centre, in accordance with his ACCT careplan. The man's family were concerned that while he was at Brixton, he did not look after his personal hygiene or appearance as he normally did. They thought that this was a sign of his depressed mental state. My investigator asked the nurses who looked after the man on the healthcare centre whether they had noticed a deterioration in his appearance. The senior nurse remembered that the man was not a particularly tidy prisoner. She said that she used to ask him to clean up his cell, but he would tell her that he was lazy and would get round to tidying his cell later. The nurse said that the man's untidiness was not so severe as to give her cause for concern. It is a marked contrast from his tidiness in Feltham, which earned him second place in a cell cleaning competition. While I respect the nurse's judgement at the time, I hope that the Head of Healthcare will ensure that prisoners are encouraged to look after themselves and their personal belongings to encourage positive mental well being.

74. The man's mother and sister also told my investigator that they were surprised not to have been contacted by Brixton for the duration of the man's time at the prison. While he had been at Feltham, staff there had kept in touch by telephone and told them about the man's progress in the healthcare centre. On one occasion, they even attended Feltham for an open day. By contrast, they did not have any contact with staff at Brixton. The man's sister recalled speaking to a chaplain, but there are no records of that contact in the chaplain's log. They were especially concerned that they were not told when the man's ACCT document was closed or that he had been discharged from the healthcare centre.

75. The temporary Head of Healthcare at Brixton agreed that family input can be a valuable source of information when caring for a prisoner with mental health problems. However, he did point out that, as an adult male prison, Brixton receives different funding and has different pressures to those in a YOI, like Feltham. He said that the pressures and relative staffing levels make it difficult to compare the services delivered to prisoners and their families. I was pleased to discover that the Head of Safer Custody nevertheless plans to make reference to the importance of family contact in the revised ACCT process. I

also understand that the revised policy for discharging prisoners from the healthcare centre to a residential wing have been amended to remind staff to consider contacting a prisoner's family, if appropriate. I agree that the nature of Brixton's ever-changing population and significantly lower minimum staffing levels at an adult male prison must make it difficult to prioritise family involvement in the care of each prisoner. However, I am pleased that prison management recognises that such communication can help the individual but also the prison in delivering informed care. Even if staff do not contact the family themselves, the importance of family contact must be recognised:

The Head of Healthcare should remind staff to encourage prisoners on ACCTs to speak with their supportive family members where appropriate. This should be included in the local suicide prevention policy.

76. In their response to the draft report, the family asked me to consider the involvement of family in the ACCT document by prison staff. As I have said above, a prisoner's family is a valuable source of support at a time of crisis. PSO 2700 asks Governors to consider the appointment of a family contact officer. I hope that the Governor will consider such an appointment, although I understand the difficulty of delivering this service in such a busy local environment.

The man's ACCT document

77. The man was on an open ACCT when he arrived at Brixton. At that time, he was subject to a low level of monitoring, with only at least three significant entries per shift. It was appropriately reviewed on his arrival and ACCT case reviews were held in accordance with PSO 2700, (the order that governs Suicide Prevention and Self-Harm Management). References to self harm were appropriately recorded. When the man said that he had cut himself on 26 July, the senior nurse examined the scars on his arms and determined that they were not current. Another nurse attended the majority of the man's ACCT case reviews, ensuring a continuity of input from one named member of staff.

78. The ACCT ongoing record showed that a number of staff recorded the man actively engaging with the wing's regime. He attended occupational therapy and associated with prisoners and staff. The man was described as "quiet", but was often seen chatting to his cellmate or watching television. No concerns about self harm were noted in the month of August.

79. On 29 August, two nurses took part in an ACCT case review. The man was at the meeting. One of the nurses signed the case review but said that the other nurse was the case manager. The case manager was aware of the man's anxiety about his upcoming court appearance. He cannot remember attending the case review on that occasion. His entries in the man's ACCT document show he observed an improvement in the man's mental state. I am surprised that the case manager thought that the man was less at risk of self harm, despite his anxiety about the court appearance.

80. The other nurse at the ACCT review said that it was a team decision to close the man's ACCT document. He described the man as having "settled" and said that the man no longer wanted to be subject to ACCT procedures. The man was already assessed as "low risk". He had been subject to monitoring with at least three significant entries per shift when he arrived at Brixton from Feltham, and the risk level was never changed. It is regrettable but not unreasonable for the man's ACCT to have been closed, given his low level of observation at the time of the review.

81. Later in his interview, my investigator asked the nurse at the ACCT review about whether he thought the man should have been moved to A wing so soon after being taken off suicide prevention measures. The nurse said that he was not personally involved in the decision to transfer the man to A wing.

82. The man did seem to settle in the healthcare centre. He continued to report aural hallucinations during his time there, but these were symptomatic of his mental illness, rather than an indication of his risk of self harm. I am careful not to use the advantage of hindsight in my investigations. I am aware that the man had a court appearance on 11 September and that might have increased his level of risk. However, as I am about to examine, he had every reason to believe that he was being transferred to a mental health setting eventually. I accept that, at the time the nurses made the decision to close the man's ACCT document, with his agreement, the level of risk he posed to himself appeared to have reduced. The psychiatrist said that he spoke to the man on 31 August, when he decided he should be discharged after the weekend. The psychiatrist said of their conversation: "he was quite clear, absolutely adamant that he had no ideas or intentions about harming himself or suicide issue".

83. It was only as the events of the next week unfolded that this decision should have been reviewed.

Transfer to a mental health setting

84. The clinical reviewers recommend that the following should be reconsidered:

> "the basis for the decision that the man was to remain in prison for the time being rather than be transferred to a more therapeutic environment on a more urgent basis"

85. The man was due to appear in court on 11 September, six days after he died. He had pleaded guilty to his offence but his sentencing was adjourned while the court waited for psychiatric reports to be compiled. One such psychiatric report was written by another psychiatrist. In his report, the other psychiatrist found that the man had developed schizophrenia in 2005. He felt it would not have been appropriate to transfer the man to a mainstream mental health setting because of the:

> "very disruptive and harmful impact of his anti-social behaviours on other residents, and his repeated failure to respond to interventions to manage his anti-social behaviours in these more open settings".

In his report, the psychiatrist recognised the need for further assessment and possible treatment in a forensic mental health setting.

86. In his interview with my investigator, the psychiatrist at Brixton said that he had also been asked to write a psychiatric report for the purposes of the man's court appearance. The psychiatrist had discussed the possible outcome of the man's court report with him. He said that the man understood he was likely to receive an order to transfer him to a mental health setting. The psychiatrist explained that a non-urgent transferral court order could be given by the judge in light of the psychiatric reports. The man would return to Brixton and wait until he was transferred to a mental health setting for treatment. The psychiatrist said that the man might have waited "months" before he was transferred.

87. The psychiatrist at Brixton told my investigator that he agreed with the other psychiatrist's view that the man should be non-urgently transferred to hospital. In his interview, the psychiatrist at Brixton explained the difference between the options available to him and concluded no other psychiatrist, " … I or anybody in the team, as I understand it, thought that [the man] required urgent transfer out of Brixton".

88. Although the clinical review challenges this decision, I find it difficult to do so. Demonstrably, the man was suffering from a mental health condition, but it was the opinion of three psychiatrists who worked with him and the team that surrounded him that he should be transferred on a non-urgent basis to a secure setting for mental health treatment. In the light of such expert judgment, I can only uphold their view.

The man's transfer to A wing

89. The psychiatrist at Brixton told my investigator that the decision to discharge the man from the healthcare centre was collaborative. He said he continued to assess the man's progress on wing rounds and nursing staff began to approach him, suggesting that it was time that he left the healthcare centre. The psychiatrist explained that the decision is reached through formal conversation in ward rounds and in the nursing station, as well as informal conversations among staff and did not name specific indiviudals who made a contribution to the decision. When asked why the man was discharged, the psychiatrist explained that the healthcare centre at Brixton is a a "very disturbed place". He went on to say that it is "architecturally, geographically completely unsuitable for the care of seriously mentally disordered people". The healthcare centre has been condemned by the Prisons Inspectorate and the Department of Health as "completely unfit for purpose". As well as the difficulty of delivering care in the healthcare centre, the psychiatrist said that discharging the man was intended to give him access to a "wider range of activities", such as the gym and education. Although there are some activities on the healthcare centre, they are limited. Finally, the man would continue to receive mental health intervention from the mental health outreach service because a referral had been made.

90. I agree that it must be difficult to deliver a therapeutic regime for mentally disordered prisoners in the healthcare centre at Brixton. The environment is restrictive and activities limited. The man's ACCT record documented that he had adjusted to life in the healthcare centre. However, he had told the senior nurse that he was too "lazy" to keep his personal hygiene and cell clean. With that in mind, it was not unreasonable for staff to want the man to be given more activities to challenge his lethargy. I do not criticise the decision to discharge the man in itself. However, like the clinical reviewer, I am concerned about the "sequence" of the closure of the ACCT document and the discharge to the wing. I also examined the discharge process, which, in my view, falls short of the expected standard of care. In their response to the draft report, the family raised concern about the nature of the decision to discharge the man. They are concerned that the decision was not taken at a multi-disciplinary meeting. I understand from the account of the psychiatrist that there was full consultation about the man's discharge with members of healthcare staff, although I agree that a formal meeting to discuss his discharge could have been appropriate.

91. The senior nurse spoke to the man shortly before he was discharged from the healthcare centre. She recalled that he always spoke about returning to the "hospital", (a mental health setting), for treatment. She thought he seemed upbeat about his transfer and he said "bye-bye, I'll see you" to her as he was leaving the wing. The pscyhiatrist told my investigator that the man understood he was likely to be transferred to a mental health setting. When my investigator asked senior nurse, who oversaw the discharge process as the Nurse Manager of the healthcare centre at the time, whether the man was upset about his upcoming court appearance, she said that they did not speak about it.

92. The man was escorted by an officer between the healthcare centre and A wing. The officer worked on the healthcare centre and it was a routine part of his job to escort prisoners who have been discharged from the healthcare centre to a residential wing. When he spoke to my investigator, he specifically recalled escorting the man between the healthcare centre and the residential wing. He remembered that the man was upset during the short walk between the wings. The man told the officer that he thought he would no longer be transferred to outside hospital if he was being discharged from the prison healthcare centre.

93. I am concerned that the man apparently believed that his transfer to ordinary location meant that he would no longer go to a mental health setting. I accept that this may have been explained to him, but he panicked in his anxiety about being discharged. However, I think that every effort should be made to explain to prisoners about their continued care plan upon discharge. This should include reference to ongoing mental health treatment, assessments and referrals.

The Head of Healthcare should review the discharge policy to ensure that staff explain to prisoners their ongoing care plan.

94. When the man was transferred to the residential wing on 4 September, staff who received him onto the wing did not know that he had been on an ACCT document until five days previously. The "Medical Liaison Form" in use at the time comprised of two parts, one for officers and one for medical staff. The part

passed to officers only indicated if a prisoner was subject to "Current F2052SH". (F2052SH) was the suicide and self harm monitoring system before ACCT was introduced.) The senior nurse correctly indicated that the man was not subject to current F2052SH at the time that he was discharged from the healthcare centre. However, there was no requirement for further information about his previous history of self-harm and the very recent closure of his ACCT. There was no mention of the outstanding post-closure review, due to be held on 15 September. In fact, the ACCT document is passed to the Safer Custody office to oversee the post closure reviews, in order to ensure that the reviews take place. While this is a commendable system to ensure that post-closure reviews take place, it meant that staff on the wing would not have been aware of the man's previous risk of self harm until his post-closure review took place on 15 September, ten days after he arrived on the wing. The man was due to be sentenced on 11 September, which was a stressful prospect for him. Indeed, there was no record that the man's ACCT document had been so recently closed on the wing at all. All A wing officers who my investigator spoke to commented that the information about the man's ACCT would have been useful to know, to inform their care of him.

95. The senior nurse made no mention of the man's mental health issues on the section of the medical liaison form on the officer's section of the form. In the section of the form destined for medical staff on the wing, there is a space for the discharging nurse to complete the prisoner's diagnosis and the medication that he takes. Both sections have been left blank. When asked why at interview, the nurse explained that he was to be escorted from the healthcare centre to A wing by an officer. The officer would carry the form. The senior nurse said that his diagnosis and prescription could not be seen by the officer because that information was 'medical in confidence'.

96. I am concerned that this liaison form is the link between the staff that have known the man and those who are about to care for him. Confidential medical information must be communicated between the healthcare and residential staff when discharging a prisoner with ongoing medical needs. Placing the form in a sealed envelope would have protected the information from non-medical staff. Keeping information medical in confidence does not preclude information sharing in more general terms. I have come across good practice in other investigations, whereby healthcare staff told wing staff to contact them if a prisoner starts behaving in certain ways. For example, in their response to the draft report, the family suggested that consent could be sought from a prisoner on arrival at a prison for medical information to be shared where necessary.

97. During interview, the senior nurse agreed that there was a "gap" in communication between the healthcare centre and the wing. She recognised that this was a lesson that Brixton could take forward from the man's death.

The Head of Healthcare must strengthen the discharge policy to ensure the full briefing of officers on residential wings, including information about recent ACCT documents.

The family welcomed the Brixton psychiatrist's suggestion at interview that the Head of Healthcare should appoint a pathways manager to ensure the effective sharing of information. I commend this suggestion for further consideration.

The man's prescription charts

98. The man's prescription charts for his time at Brixton were not made available to my investigator. They were not withheld, but could not be found. There is no confirmation that they accompanied the man to the wing. The arrangements for the transfer of the man's medication were too relaxed. The senior staff nurse said that she verbally told the pharmacist that the man was being discharged to A wing and the pharmacist would have taken the medication and the chart to the wing's treatment room.

99. I am disappointed that the clinical review does not comment on the seriousness in such a serious lapse in healthcare delivery. However, the clinical review does make the following related conclusion:

> "Risperidone is a drug that has a long half life in the body. [The man] had been taking the drug for a period of time, so the blood levels of the drug would have reached a steady state. Consquently, it is very unlikely that missing a single dose of medication would have an immediate significant adverse impact on his mental state."

100. Without sight of the prescription charts, it is impossible to demonstrate that the man took his appropriate medication. The nurse in the treatment hatch when the man arrived on A wing described the process for inpatients collecting their medication in the healthcare centre. Any non-compliance would be followed up with a conversation between a member of staff and the prisoner. Healthcare staff remembered the man collecting his medication as required most of the time he was in the healthcare centre. The man's mother told my investigator that she was particularly anxious about the effect that a missed dose would have on his mental state. Although physically, the clinical review can reassure her that missing a single dose would not have affected him, it is not possible to determine what emotional impact a missed dose would have had at such a stressful time.

The Head of Healthcare and the Governor must enforce robust systems for the transfer of prescription charts and medication to the wing upon discharge from the healthcare centre.

The allocation of the man's cell

101. Following his arrival on A wing, the second landing officer located the man in a cell with another prisoner. The man's cellmate was described by several staff as "disordered". The cellmate was in his cell overnight between 4 and 5 September. If there was any suspicion of third party involvement, my investigation would have been suspended, until the police had either brought criminal charges or ruled out such a course of action. The police ruled out his involvement in the man's death immediately and my investigation proceeded.

102. My investigator met with the man's cellmate at the beginning of her investigation process and, although she is not a clinician, she found him to be severely affected by alcoholic dementia. The senior nurse was concerned that the man had been located in a cell with someone who was severely affected by dementia, given his own mental health issues. An A wing officer said that as a medium risk, the man could have been located with anyone. His cellmate was also assessed as medium risk at that time. (Subsequent to the man's death, his cellmate's cell sharing risk assessment was reviewed and he was found to be 'high' risk and only located in cells on his own.) The A wing officer said that it would be "good practice" for staff who had known the man to make an entry in his wing history about his history of vulnerability so that could have informed the decision about where to locate him. Ultimately, the A wing officer thought that the priority for A wing was to find spaces for prisoners. During his interview, the officer suggested: "it could have been because it was easier enough to put him in with that prisoner because that other prisoner didn't complain". I understand that this is the opinion of one officer, but I am concerned at the suggestion that a prisoner might be located with another prisoner with mental health issues because they are less likely to complain about each other.

103. In their response to the draft report, the man's family wrote of their concern that his cell sharing risk assessment was not reviewed at the time of his discharge. Cell sharing risk assessments for prisoners assessed as medium or high risk should be reviewed after one month. There is no evidence from the man's records that such a review took place. I agree with his family that a review of his risk assessment would have been timely as he was being discharged to the main residential wing.

    The Governor and the Head of Healthcare should consider introducing a system to review cell sharing risk assessments when a prisoner is being discharged from the healthcare centre.

104. The second landing officer remembered locating the man with his cellmate. He said he was working on the second landing and he was given the cell number. He recalled that there were no other spaces available. When they got to the cell, the officer recalled that it was dirty. He said that he asked the man's cellmate to tidy it up. The man hesitated before he went into the cell and he asked to be located in a different cell. As there were no other cells available, the second landing officer asked him to stay in that cell overnight and then ask to be moved in the morning. The man agreed and entered the cell. I am extremely concerned that the man was located with a prisoner with such extreme mental health issues. I am further worried by the state of the cell that the man was expected to share. Cells at Brixton are not large and we should not underestimate the impact that this arrangement may have had on the man's mental state.

105. I acknowledge the difficulty of managing huge numbers of vulnerable prisoners on overcrowded wings. If officers had information about the man's level of risk and mental health problems, they might have allocated him a different cell.

Again, this is a stark reminder of the importance of information sharing between healthcare staff and prison officers about the needs of vulnerable prisoners.

The events of 5 September

106. My investigator was surprised to find only three staff statements were made to the Governor about the events of 5 September. There is a formal requirement is set out in PSO 1400 – Incident Reporting for staff to make statements following a death in custody. When my investigator raised this with the Governor, he shared my concern that more statements had not been taken. He assured my investigator that such statements are routinely taken following a death in custody and that action would be taken to ensure that in any future cases, statements would be taken from all staff involved.

The roll count

107. During interview with the night officer, he could not be absolutely certain that he completed a full roll check before he went off shift. He said that he was carrying out ACCT checks on the landings, including one ACCT check every ten minutes. He explained that this interrupted him while he was counting prisoners on each landing. He said that he thought he would have looked in the man's cell. He said that at the time he carried out the roll check, it was sufficiently light that he would have seen a prisoner hanging from the window in the cell. The night officer signed to say that he had completed a full roll check and that the numbers tallied with the check the previous evening. The A wing officer who came on duty at 7.15am, explained to my investigator about the lack of clarity about who does the morning roll count.

108. Due to the man's physical condition at the time that he was found, it is likely that he was hanging in his cell from the early hours of the morning, at the end of the night shift and the beginning of the day shift. He was described as cold and stiff, which means it is likely that rigor mortis has set in. (Rigor mortis usually occurs approximately three hours after death.) The night officer told my investigator that it was light enough to see into the cell at that time of the day in September. Therefore, it is unlikely that a full roll count was carried out by either the night officer leaving duty or the day staff coming onto their shift. The night officer did not discharge his duty by failing to carry out a full roll count. If he felt unable to carry out a full check, he should have alerted his colleagues to ask for assistance. During the course of the investigation, my investigator received notice from the Governor that disciplinary investigation has taken place following this matter.

109. Clearly, the night officer was not the only one at fault. There was some confusion about the responsibility of day staff to conduct their own roll count.

The Governor must ensure that there is clear system should be introduced to ensure that the chain of custody is effectively transferred from shift to shift.

110. The man had died several hours before his discovery. The post mortem process cannot determine a specific time of death. Therefore, it is impossible to determine if a timely and effective roll count could have saved his life.

Staff shortages

111. A number of staff told my investigator that they were suffering from stress because of the low level of staffing at Brixton prison. On the morning of 5 September, there was a significant staffing problem on A wing. Instead of the required senior officer plus seven officers, the B wing SO explained that he was reassigned to A wing upon arrival at the prison that morning, as opposed to B wing where he was routinely scheduled to work. When he arrived on A wing, he discovered that he had only two officers to support him in his duties.

112. During interview, my investigator asked the B wing SO why there were so few officers on duty that morning. I am extremely grateful to B wing SO for keeping an exact record of the whereabouts of the officers assigned to A wing:

> "A Wing officers that were supposed to have worked that day - Officer [A]: she was sick; Officer [B]: on annual leave; Officer [C]: sick; Officer [D]: on a bed watch; Officer [E]: on a bed watch; Officer [F]: she was one of the one's in, she was working on the desk; Officer [G]: on the fours; Officer [H]: on nights, and that's it. That's all I had."

113. The B wing SO explained the impact that had on delivering the routine that morning. The list of prisoners to be released for freeflow did not arrive on the wing until around 9.00am and the list of prisoners to receive treatment may have arrived later still. As a result of the staff shortage and the freeflow list not being on A wing, the regime was delayed and freeflow did not take place until around 9.30am. All prisoners who remained on A wing were released for association at 9.45am. At this time the man's cell was unlocked by the visits officer.

114. The staff shortages that morning, combined with the probable missed roll count, meant that the man was not discovered for many hours after his death. I understand that he might have died in a matter of minutes, and an earlier discovery might not have saved the man's life, I am concerned that his dignity was hugely compromised by such a long delay.

115. From the B wing SO's account, it is clear that many of the absences that morning could not have been anticipated. However, I am disappointed at the staffing levels that morning. Not only does it put staff under immense pressure, it adversely affects prisoners' regime. The family were particularly concerned that there appeared to be no handover between the shifts. The Governor assured my investigator that such staffing shortage was extremely rare at Brixton. The B wing SO said that such a low level of staffing was unusual and he did his best with the staff that he had. I reluctantly accept that staffing levels can fall far short of the required minimum due to circumstances outside of a prison's control.

116. More generally, staff spoke to my investigator about a feeling of low morale caused by staffing levels. My investigator asked the Head of Human Resources at the prison to provide her with an analysis of staffing levels from August, September and October 2007. These were to take into account a change of routine which has further reduced the number of staff on duty. Unfortunately, such a broad analysis was not forthcoming. The Governor assured my investigator that they do not have a general staffing issue at the prison. Even if this is the case, the perception of some officers is that they are not well-supported by a full team of colleagues. I hope that staff and governors work together to improve morale at Brixton.

117. In general, staff have said that they felt well supported by the prison following their involvement on 5 September. Those who attended the hot debrief told me that they found the meeting useful. I also understand that healthcare staff held a meeting following the man's death, chaired by the psychiatrist, which has been described as helpful by staff.

The response attempt

118. The B wing SO described the man as "stiff" and "cold" when the visits officer and he first went into his cell that morning. The B wing SO said that he could not be certain that the man was dead and appropriately treated the situation as a medical emergency.

119. The revised clinical review made the following observation about the response attempts:

> "From the descriptions given, the body of [the man] was already cold and stiff. While resuscitation would clearly have been of no avail a full attempt was made.
>
> The transcripts of interviews provide a reasonable amount of information about the sequence of events around the resuscitation attempt though there is insufficient detail to form a detailed review of the individual steps taken.
>
> However, with this proviso, the following observations are made:
>
> The initial attempts at resuscitation appear appropriate. The descriptions of the actions of [the B wing SO] and [the visits officer] taken from [the B wing SO]'s statement suggest that they attempted what is described by [the B wing SO] as CPR.
>
> The equipment and the clinical team arrived promptly from A wing. Again the descriptions are imprecise but it would seem that emergency equipment and the staff trained to use it were available in [the man]'s cell within minutes.

> The description of the next stages also sounds appropriate. A defibrillator was applied. It showed no signs of a pulse. A clinical assessment was undertaken and [the man] was pronounced dead."

120. The transcripts referred to in this passage are those of the interviews undertaken by my investigator. The clinical review team were asked by my investigator to undertake joint interviews with healthcare staff, which would have given them the opportunity to ask relevant clinical questions. Unfortunately, they did not take up this request and carried out their review independently.

121. The man was probably dead at the time that he was discovered, and was likely to have been dead for some time. Staff acted promptly once their attention was drawn to him by prisoners but the delay in discovering him meant that little could be done to change the outcome. I am satisfied that the response to discovering the man in his cell was appropriate.

Conclusion

122. The man's care was fatally compromised by two decisions made in close proximity: the decision to close his ACCT document and the decision to discharge him from the healthcare centre. Each decision was reasonable and justifiable in itself. However, closing his ACCT document days before he was discharged to a residential wing meant that crucial information about his level of risk was lost.

123. I am pleased that Brixton's healthcare discharge policy has been strengthened since this investigation took place. The man's story underlines the importance of effective communication between staff, prisoners and their families when dealing with vulnerable prisoners.

124. Finally, I am extremely concerned about the events of the 5 September. The apparent failure to carry out a roll count, coupled with extraordinary staff shortages, meant that the man was not discovered for hours after his death.

125. Although I make comparatively few recommendations in this case, my investigation uncovered a number of inadequacies. I am grateful to the Governor of Brixton for his co-operation with the investigation and keeping my investigator informed with the progress that Brixton has made following the man's death. I hope that the learning from this grave investigation continues.

RECOMMENDATIONS

1. **The Head of Healthcare should remind staff to encourage prisoners on ACCTs to speak with their supportive family members where appropriate. This should be included in the local suicide prevention policy.**

   The Head of Healthcare partially accepted this recommendation. In response, they explained:

   "Where and when appropriate healthcare staff will endeavour to involve supportive family members. However, assessment of the relationship requires a full risk assessment in partnership with the prison and full confidentiality and written consent to information sharing by the patient, in-line with healthcare information governance policies and procedures. All Prisoners on ACCT will be asked if they wish a specific family member to be sent information and if appropriate under PSO4400, information regarding the ACCT process and the individual will be sent to prisoner's family to encourage communication."

   In their response, the Prison Service indicated that this action had already been completed.

2. **The Head of Healthcare should review the discharge policy to ensure that staff explain to prisoners their ongoing care plan.**

   The Prison Service accepted this recommendation, with the following response:

   "This was previously reviewed in June 2008. This policy and procedure will be reviewed again and procedures put in place to ensure all staff are aware of the procedure."

3. **The Head of Healthcare must strengthen the discharge policy to ensure the full briefing of officers on residential wings, including information about recent ACCT documents.**

   During the course of the investigation, the Governor and the then Head of Healthcare assured my investigator that this was a matter already identified by the prison as requiring development. The Prison accepted the recommendation and wrote the following response:

   "The procedure will include clear guidance on liaison with duty governor and wing staff. Wherever possible there will be a phased return to ordinary location on C Wing jointly planned with the Wing Manager."

4. **The Head of Healthcare and the Governor must enforce robust systems for the transfer of prescription charts and medication to the wing upon discharge.**

   The recommendation was accepted, with the following statement:

"The patient should be transferred to the Wing with all documentation and medication."

5. **The Governor and the Head of Healthcare should consider introducing a system to review cell sharing risk assessments when a prisoner is being discharged from the healthcare centre.**

6. **The Governor must ensure that there is clear system should be introduced to ensure that the chain of custody is effectively transferred from shift to shift.**

   In response to this recommendation, the Prison Service wrote:

   "A review was completed and Staff Information Notice issued."