Investigation into the circumstances surrounding the death of the man at HMP Brixton on 28 September 2004

Report by the Prisons and Probation Ombudsman for England and Wales

September 2005

This is the report of an investigation into the death of a man at HMP Brixton on 28 September 2004. The man was on remand, awaiting sentence, and had been in Brixton for eight days when he died. The purpose of my investigation was to establish the circumstances and events surrounding the man's death, including the quality of care provided by the Prison Service.

In April 2004, my office was passed the responsibility of investigating all deaths in custody. Under transitional arrangements, a Governor within the Prison Service's London Area Manager's Office was appointed to conduct the investigation on my behalf and one of my colleagues was my representative on the investigation. I am grateful for all the assistance that the investigation team received from the Deputy Governor of HMP Brixton, and from his staff, including the establishment's Liaison Officers.

A key objective of the investigation was to make sure that the man's family had the opportunity to raise any concerns they had about his death. The investigation team was able to meet with the man's mother and his estranged wife. I am most grateful to them for having these meetings at what must have been a very difficult and distressing time for them. The investigation team also had telephone contact with the man's girlfriend and met with the man's father after disclosure of the report.

I offer sincere condolences to the man's family and friends in their sad loss.

STEPHEN SHAW CBE
PRISONS AND PROBATION OMBUDSMAN SEPTEMBER 2005

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SUMMARY

On 17 August 2004, this young man of 23 years was remanded into custody at HMP Pentonville, accused of offences against his estranged wife. The Prisoner Escort Record (PER) which accompanied him from Thames Magistrates Court noted that he suffered from depression but did not provide further details. There was no mention of any self harm or suicidal intentions. The subsequent reception health screen noted that he had been taking anti-depressants, but that he had stopped taking them a few months before. The man said that he had taken an overdose in prison in 2000. Prison Service records showed that he might have been in custody in Feltham Young Offender Institution (YOI) in 2000 but this could not be confirmed. The doctor prescribed a one off dose of medication to help him sleep and described him as 'somewhat low'. There was no real cause for concern documented and he was located on a normal residential unit.

On 21 September 2004, the man was remanded into custody in Brixton, to await Probation Service reports before being sentenced. He said that he did not have any thoughts of suicide or self harm and was placed on normal location. He was located in a cell with another prisoner. On 28 September at 1.17am, his cellmate attempted to hang himself in the cell by attaching a ligature to the cell window. The man supported his body until the staff on duty came to his assistance. His cellmate was given medical attention and placed on a F2052SH (suicide/self harm warning form) and the Senior Officer in charge of the Wing spoke to the man. Both men said they were content to return to the same cell.

The cellmate went to Court during the morning of 28 September and the man was left in the cell alone. No further support was given to the man. Another prisoner arranged to relocate to the man's cell but he did not go through with the move as the man told him that he was going to kill himself. He told other prisoners about this and they told a Senior Officer on duty, Senior Officer A. She spoke to the man but he denied that he had any suicidal thoughts. She thought that the prisoners were confused with the event during the morning when the cellmate had attempted to kill himself. At around the same time, Brixton received a telephone call from the man's partner. She spoke to the Duty Governor, and expressed concerns about the man's wellbeing following a number of telephone conversations she had had with him that day. The Duty Governor asked another Senior Officer on the Wing, Senior Officer B, to make enquiries and report back to him. Senior Officer B had a lengthy conversation with the man who convinced him he was fine. Senior Officer B spoke to Senior Officer A and she mentioned the earlier concerns from prisoners. Senior Officer B spoke to the man again and he again convinced him he was alright.

During the afternoon of 28 September, a Suicide Prevention Team meeting was held and discussed the case of the man's cellmate. The attendees decided that the cellmate should be relocated to Healthcare when he returned

from Court. This was not documented in the minutes of the meeting and the group did not take responsibility for ensuring that this happened.

Meanwhile, the man's partner had phoned back to see how he was. It is not clear to whom she spoke but it appears that she did not speak to the Deputy Governor or any member of staff on A Wing. She told the investigation team that the person she spoke to was very unhelpful and dismissive of her concerns.

Shortly after, the cellmate returned from Court and was relocated back to the cell with the man. He was not located in Healthcare as agreed in the Suicide Prevention Team meeting. On entering the cell, the cellmate immediately discovered the man hanging.

The man left a note which said that no one was responsible for his death and apologised to prison staff for lying to them. He said that no one could help him and he wanted to die.

This report makes a total of 14 recommendations.

CONDUCT OF THE INVESTIGATION

1. The investigation was conducted by a member of the Prison Service's London Area Manager's Office. The investigation was led by one of my senior investigators.

2. During the course of initial inquiries, the investigation team were shown around the prison and visited the cell where the man died. They also reviewed all the relevant documentation and established a chronology of events. Notices were issued to staff and prisoners telling them of the investigation and offering them the opportunity of contributing.

3. One of my Family Liaison Officers contacted the man's family and offered them the opportunity to meet with her and the senior investigator to discuss the purpose of the investigation and to raise any concerns or questions that they would like explored and addressed. A meeting took place with the man's mother, on 14 December 2004. A separate meeting took place with the man's estranged wife, also on 14 December 2004. The man's partner detailed her concerns in a telephone conversation on 24 November 2004. The man's father met my investigator, through his representatives, after the draft report was issued.

4. The investigation team met with the Chairman of the local Prison Officers' Association (POA), and the Chair of the Independent Monitoring Board (IMB) to tell them about the investigation process. Sixteen members of staff and eight prisoners were interviewed during the course of the investigation. All members of staff were offered the opportunity of being accompanied by a work colleague or Trade Union official.

5. The investigation team also contacted Her Majesty's Coroner to tell him of the nature and scope of the investigation. The Coroner provided a copy of the Post Mortem report of 29 September 2004. This recorded the cause of death as 'hanging, self-suspension'. There was no evidence of any third party involvement. The report said that there was no evidence of any natural disease that could have caused or contributed to the man's death or that he had been subjected to an assault or restraint. There were signs of old injuries, which were superficial scars, on the man's left upper forearm consistent with previous deliberate self-harm.

6. The investigation team had a telephone conversation with the police officer responsible for investigating the incident on behalf of the Metropolitan Police. He was advised of the scope of the investigation. He was offered the co-operation of the investigation team and the sharing of any information which might be relevant to his inquiry.

7. I am grateful to the doctor from Lambeth Primary Care Trust, who undertook a clinical review of the healthcare provided to the man while at Brixton.

BACKGROUND INFORMATION

The man

8. The man was born on 21 October 1981, and was 23 years old when he died. He was remanded into custody at Brixton on 21 September 2004. He had been convicted of two offences against his wife, assault causing actual bodily harm and threats to kill. He was remanded into custody to await Probation Service reports before being sentenced. He suffered from depression for which he had been prescribed medication before his remand into custody.

9. The man's mother told the investigation team that the man's father had taken her and their two children to Bangladesh in 1990. She returned to England without the children and she and her husband subsequently divorced. The man's father remarried when the man was 14 years old. The man and his sister returned to England from Bangladesh when they were teenagers and later resumed contact with their mother. The man's mother said that he suffered from depression and high blood pressure. She believed that the events of his childhood might have caused some of the depression, having been taken from a comfortable life in London to Bangladesh, and subsequently separated from her. She also said that he would not take medication for his condition. She had spoken to him in May or June 2004 and had sensed something wrong in his voice. He told her that he was depressed and she told him to see his GP.

10. The man's father provided a statement to the investigation team. He said that he was the first born child in his family and was loved dearly by all the family especially by himself and his brother (the man's uncle).

11. The man's estranged wife told the investigation team that she had been married to him for four years, having known him for approximately five years. She described their relationship as a violent one. She had split up with him in June 2004 after finding out in December 2003 that he was having an affair. She said that she had not confronted him about the affair immediately, as his grandmother had become ill and subsequently died and she did not want to upset him further. When she finally confronted him he denied the affair. She then asked for a divorce and she believes this led to him threatening to kill her and his subsequent arrest.

12. The man had worked as a health advocate at a local hospital. A colleague of his told his estranged wife that he mentioned to her some time in August 2004 that his neck hurt as he had tried to kill himself but his partner had stopped him. His colleague also told him personally to get help. His estranged wife had also witnessed attempts of self-harm and suicide by him. She believed that he always made such attempts when somebody was around to stop him. She suggested he might have done this in Brixton in the belief that he would be saved. She described him as being childlike and not able to talk openly about his feelings. She said that he always needed someone with him and did not like to be alone.

HMP Brixton

13. Brixton is a local prison and its main function is to serve the Inner London and Southwark Crown Courts, holding remand and recently convicted prisoners. Convicted prisoners have an initial interview and are then categorised and allocated to another prison with facilities appropriate to their sentence and sentence plan needs.

14. The prison consists of four main residential units plus the Healthcare Centre. The accommodation consists of 449 cells, mostly occupied by two prisoners in each cell. The Healthcare Centre has 36 available beds. On 28 September 2004, Brixton held 768 prisoners. A Wing, where the man was located, held 260 prisoners.

15. The local strategies for the care of prisoners at risk of self-harm at Brixton are in accord with national policy. The local policy for the prevention of suicide is published within the prison and is available to both staff and prisoners. The establishment employs a full-time Suicide Prevention Co-ordinator, a Senior Officer, who holds regular meetings with all departmental area representatives. A number of initiatives in the prevention of both self harm and attempted suicides have been implemented. One such initiative is a dedicated telephone number for friends or relatives of prisoners to phone the prison if they have any concerns about a prisoner. This is the 'at risk line' and telephone calls to this line are recorded on an answer machine which is checked four times a day. Calls received are logged and a record is made of any actions taken in response. Messages left can be checked by staff from any telephone within the prison by dialling the at risk telephone number. This facility has been in operation since the end of August 2004.

16. The training manager for Brixton, was interviewed to establish the amount of training that staff in Brixton received in Suicide Prevention and First Aid. He confirmed that he had been in the role since June 2004 and that training records relating to staff training before that are very sketchy. He was not surprised to learn that an officer told the inquiry that he had not received any first aid training for over 14 years. He said that first aid training is not available for every officer but is for new first aiders and there are refresher courses for those already trained. Refresher courses are every three years, to keep first aid certificates up to date. He said that emergency aid or heart start training is given to all new prison officers. He confirmed that CPR training had been carried out recently, which was targeted to certain members of staff, mainly healthcare staff. He said that Brixton did have sufficient staff trained in first aid to fulfil the requirements of health and safety and that those staff did receive continued training. However, there is no system in place to prevent these trained staff being off duty at the same time.

17. Records show that there has been another self inflicted death at Brixton, in April this year, which my office is investigating. There do not appear to be any common issues identified in that investigation (although that report is not yet finalised).

THE EVENTS LEADING UP TO THE MAN'S DEATH

The man's custody at Pentonville and reception at Brixton

18. The man was received into custody at HMP Pentonville on 17 August 2004 from Thames Magistrates Court. He was remanded for offences of actual bodily harm and threats to kill. The accompanying Prisoner Escort Record (PER) from the court to the prison did not indicate on the risk categories that he was suicidal or likely to self-harm. The word 'depression' was recorded under 'further information about risk' but this entry was not clarified with any other information or explored further by the interviewer.

19. During the first reception health screen assessment, the man was asked whether he had ever taken medication for mental health problems. He said that he had been taking Fluoxetine, an anti-depressant drug, but that he had stopped taking that a few months before. Pentonville did not obtain his GP medical records to clarify this point and he was not referred for a mental health assessment. When asked if he had ever tried to self harm, he said that he had taken an overdose in 2000 in prison. He had not mentioned any previous period of custody when interviewed for his prison record. To clarify this point, Prison Service computer records were checked by the investigation team. They showed that a man with the same name had been in custody at Feltham in 2000. He had been the subject of an open F2052SH (which is a form for monitoring prisoners who may be suicidal) when he was released from Feltham. The records did not indicate why the F2052SH had been opened. It was not possible to confirm, however, that this was the same man who was in custody at Brixton.

20. The man said that he did not have any current thoughts of self harm or suicide. He was assessed as being mentally stable, and did not express any negative thoughts. He asked to see the prison doctor as he needed something to help him sleep and he did not want to take Fluoxetine any longer. No reason was given. He was then seen by the prison doctor who recorded that he was 'somewhat low'. The doctor prescribed a once only dose of Zopiclone to help him sleep. The man was located on normal location within Pentonville. There are no incidents noted in his records from Pentonville to say that there was any cause for concern regarding his mental state or physical wellbeing during his time there.

21. The PER for the man's transfer from Pentonville to Thames Magistrates Court on 24 August did not indicate any known risks of suicide or self-harm. The case was committed for trial at Southwark Crown Court on 21 September. The man returned to Pentonville that day. Again there was no cause for concern noted.

22. On 21 September, the man was convicted, and remanded in custody to return to court on 19 October after Probation Service reports had been prepared. The PER for his transfer from Southwark Crown Court to Brixton again did not note any known risks of suicide or self-harm. The man was processed through reception at Brixton as a transfer from another establishment rather than as a new reception. The only documents to follow him from Pentonville were his PER and medical record. The Inmate Medical Record (IMR) completed at Brixton noted, 'Seen on reception from Pentonville via Southwark Crown Court. JR'd status. Fit and well.' A cell risk assessment form and a first night in custody questionnaire were completed. Neither assessment raised any issues of concern. The man was located on A Wing (A2-22) where he remained until 24 September 2004, when he was relocated to cell A2-03, where he shared a cell.

Incident with the man's cellmate: early morning on 28 September

23. At 1.17am on 28 September, the man called night patrol staff to his cell where they found that his cellmate had tried to hang himself by a ligature from the cell window bars. An officer, officer A, entered the cell and cut the ligature from around the cellmate's neck. The man supported the cellmate's body while this was done.

24. The cellmate said in interview that he was located in cell A2-03 with the man on 27 September. He said that the man told him that he had a girlfriend whom he loved. He could tell from the way that the man spoke that he was heartbroken at being away from her. The two men then chatted for a while. The cellmate showed the man photographs of his wife and son. The cellmate said that at about this time he made up his mind to hang himself. When the man fell asleep, his cellmate tied a ligature onto the cell window bars and stood on a chair and attempted to hang himself. The noise of the chair moving woke the man and he grabbed the cellmate and held him by the legs, supporting him until an officer came into the cell and cut the ligature from his neck.

25. Officer A said in interview that he heard the man banging on the cell door. He ran to the cell, looked in, and saw the cellmate with a ligature around his neck. The man was supporting him, although the cellmate was standing up of his own accord. Officer A entered the cell, cut the ligature from the cellmate's neck and the cellmate was removed by a member of medical staff for assessment. Officer A then took the man out of the cell to a Listener's suite and spoke to him for about 40 minutes. He asked the man what had happened and whether he was alright and the man said he was fine. Officer A said that he subsequently asked the man whether he wanted to talk to anyone and the man declined, again saying he was fine. Officer A could not remember whether he had specifically asked the man whether he wanted to talk to a Listener or a Samaritan. (A Listener is a prisoner specially trained by the Samaritans to assist other prisoners by listening to their problems.)

26. The man told Officer A that he did not have any problems with being in prison and was more concerned about his cellmate. After the cellmate had been seen by medical staff, Officer A asked him if he wanted to go back to the same cell. He replied that he did. He then asked the man whether he wanted to return to the cell with the cellmate. The man said that he would go back to the same cell and would talk to the cellmate. Both men were then locked into the cell. The cellmate was placed on a F2052SH. Officer A observed both men every 20 minutes, initially up to about 3.30am/4.00am, when he saw them talking to each other. He checked again some time between 4.30am and 5.00am and they were both asleep. The investigation team did not find any record of this.

27. Officer A woke the cellmate at 6.15am as he was scheduled to go to Court. He went back to check that the cellmate was up and found that both men were awake and they confirmed they were fine. He passed on the information about the incident to the day staff by way of a note in the Wing Observation Book. The note in the Wing Observation Book reads, 'Was alerted by cellmate that this inmate was trying to hang himself. Sealed pack was broken to gain entry to cell. He (the cellmate) had ligature tied around neck and affixed to window frame. Was cut down using big fish. After being seen by medic and given sleeping medication was relocated into cell. Was offered observation cell but he said he preferred not to be alone. Was very apologetic afterwards. F2052SH raised.' No mention was made of the man's intervention or of any support offered to him.

28. The cellmate left the prison that morning to attend Court. The man was left alone in his cell.

Staff action later on the morning of 28 September

29. Another Senior Officer on the Wing, Senior Officer C, started duty at around 7.45am on 28 September 2004. He said that he was not aware of the incident with the cellmate until he read the entry made by Officer A in the Wing Observation Book. He did not speak to Officer A about the incident as he (Officer A) had gone off duty by this time. There were no instructions left for him about further action to be taken in respect of support for the man. In fact, no mention was made in the Wing Observation Book of the man's intervention with his cellmate. Senior Officer C said that if a cellmate had been very distressed by such an incident or was himself on a F2052SH form he would expect that they would probably get follow up counselling. His understanding of this situation was that Officer A had spoken to the man after the incident and the man had confirmed that he was fine. There were no concerns for his wellbeing.

30. Senior Officer C did not carry out any follow up action for the man when he came on duty. He said, 'In an ideal world I would have liked to have been able to have had the time to go and see him, but running a wing such as A Wing, it is just not possible. To be honest with you in hindsight after this one I would like to think that in that situation, if it was to occur again, I would put everything else on hold to make sure the other prisoner was ok.'

31. Another officer on the Wing, Officer B, also started work at around 7.45am on 28 September and received a briefing from the wing manager before going to A2 landing. He was unable to remember the exact content of the briefing but vaguely recalled that he was aware of an incident with the cellmate. He said that he did not receive any specific instructions regarding the man but would generally have kept an eye on him as part of his normal duties. He said that he had little interaction with or knowledge of the man but he recalled him as being quiet, spending most of his time in his cell reading.

32. An officer, Officer C, worked on A2 landing with Officer B on the morning of 28 September. He also attended the morning managers' briefing and was told about the incident with the cellmate. He confirmed that he had not received any specific instruction in respect of further support for the man. He had not known the man as A2 landing was not his normal landing. He did not have any interaction with the man that morning.

33. The Suicide Prevention Officer, said that she was on duty on A Wing on the morning of 28 September. She was told by the Duty Governor that the cellmate had attempted to hang himself on 27 September. The Duty Governor told her that everything had been dealt with and that the man was going to be offered support and looked after that day (28 September). She said that normally she would have walked the wing as part of her morning duties, but that morning she had a visitor from Prison Service Headquarters and was not able to do so.

34. The Suicide Prevention Officer's understanding of the support offered to the man immediately after the incident with his cellmate was that Officer A spoke to him and he told him that he was fine. She understood that the man was offered the support of prison Listeners but he declined this support. She did not receive this information personally from Officer A.

35. In summary, it appears that the man was given no specific support by staff on the morning of 28 September after Officer A went off duty.

Prisoners' concerns and staff response in the afternoon of 28 September

36. Senior Officer A worked on A2 landing on the afternoon of 28 September 2004. She said that, while prisoners were on association, the man approached her and told her about the incident with the cellmate during the early hours of that morning. Senior Officer A sympathised with him about how awful it had been for him. The man wandered off after the conversation.

37. It seems that other prisoners were concerned about the man. A prisoner, prisoner A, said that the man had approached him after his cellmate had gone to Court. The man asked him if he could arrange for another Bengali prisoner to move into his cell with him. Prisoner A then arranged for another prisoner, prisoner B, to move into the cell with the man. This cell move was authorised by Officer B.

38. During association, prisoner B said he moved his belongings into the cell with the man. Shortly after this, the man told him he was going to hang himself. Prisoner B told prisoner A of the conversation, and refused to stay in the cell with the man.

39. Prisoner B also went to see Senior Officer A in the wing office. He told her what the man had said, and that he could not move into the cell with the man after all because he had said that he was going to kill himself. Senior Officer A said at interview that she thought prisoner B must be mistaken as it was the man's cellmate who had tried to kill himself, not the man. She put this to prisoner B. She said prisoner B told her that he had spoken to the man in his own language and he was still concerned that the man was going to kill himself.

40. Senior Officer A said she then went to speak to the man in his cell and he told her that he was fine. She told the man about prisoner B's concerns but he still maintained that he was fine. Senior Officer A still thought that prisoner B must have been confused so she went back and spoke to him but he was still concerned about the man. She said that she was not exactly happy that everything was fine with the man after speaking to him, but the man had assured her that he was alright. She spoke also to prisoner A, and he told her that he had spoken to prisoner B and that prisoner B was concerned that he would be blamed if the man harmed

himself. He told Senior Officer A that it would be helpful for the man to have a cellmate who spoke the same language.

41. Prisoner B never actually moved into the cell with the man. He said that he told prisoner A that the man was still on his own in the cell and prisoner A tried to get another Bengali prisoner to move into the cell.

42. Senior Officer A said she spoke to Senior Officer B, and told him about the prisoners' concerns about the man. She said that Senior Officer B then went to see the man. He concluded, as she had, that the man was fine.

43. Senior Officer A next saw the man at unlock for evening meal, although she could not recall whether he collected his meal that night. When she was locking up after the meal, she saw that the man's door was still open and he was sitting in his chair. She asked him if he was alright and he said yes. She told him that, if he did need someone to talk to, there were people in the Prison Service-not necessarily prison officers- who would help if he wanted. He told her that he was fine.

44. Finally, another prisoner, prisoner C, said at interview that he found a razor blade in the man's cell. He said that he had been in a cell with the man when prisoner B came in and told them that the man had said that he was going to take his own life. He said that both he and prisoner A then went next door into the man's cell to talk to him. Prisoner A carried on talking to the man while prisoner C looked into the cell bin and saw a razor blade. He removed this to prevent the man from harming himself with it. Officers then started locking prisoners back in their cells. He said he showed Senior Officer A the razor blade from the man's cell and told her that the man was serious about taking his own life. He said that Senior Officer A did not seem to be interested and did not even take the blade from him. He then put the blade in the bin in the man's cell. When the police interviewed him later he said they retrieved the bin with the razor blade in it. Senior Officer A denied this. She said that no prisoner told her that they had found a blade in the man's cell, or showed her any such blade. The police investigation has been unable to confirm whether a razor blade was found in the bin in the man's cell.

45. At the point that prisoners were locked up, the man remained in his cell alone.

Telephone calls made by the man to his partner on 27 and 28 September

46. The investigation team listened to a number of telephone calls made by the man, to his partner during his period in custody. Several of these contain references to intentions the man had expressed to cause himself self harm. It is clear from the telephone calls that the man believed that his partner had been lying to him and had been seeing other men. In a telephone call he made on 27 September he told her 'to move on'.

47. On 28 September at 3.02pm, the man made a telephone call during which he criticised the clothes his partner told him she was wearing and the fact that she had been to a hairdresser. He again told her to find another man and to get her mother to find her one. He said that he was not coming out of prison and that he could not be with her and did not want to live. Later on he said, 'probably if I go to heaven, but I doubt it, if you commit suicide you go to hell.' He ended the telephone call by saying 'make yourself feel better because I will as well, I'm going to kill myself, that will make me feel better, goodbye, goodbye'. His partner replied, 'No please, no don't, no, no.' The man said, 'I will, alright, you know, I don't lie, I don't lie. I will kill myself and it's only for your love because I can't have it, okay.'

48. The man made his next call to his partner at 3.22pm. During this call he was extremely upset and continuously asked her why she had lied to him. He talked again about being unhappy about her clothes and hair. He said during that call, 'I am sitting in here thinking about, trying not to kill myself every day.' When she told him she had had her hair coloured he said, 'I can't take it, why are you doing this to me, why?' He later said, 'Hope you are satisfied, but you will only see my dead body.' He continued, 'Do me a favour, give me a thousand pounds. I think that's how much it costs for the grave funeral. I want to be buried next to my gran.' He then said, 'That's why I want to kill myself because there is no way I can be with you.' The man ended this call by telling his partner that he wanted her to shave her hair off and then became upset when she refused to do so. The man made his last call to his partner at 3.40pm. He again told her to shave her hair off and that he intended to take his own life. The man made a total of six calls on 28 September between 2.48pm until his final call at 3.47pm when he phoned to check his balance, which confirmed that he had used all his money in his telephone account.

Telephone calls from the man's partner and action taken by Brixton in response

49. The man's partner told my Family Liaison Officer about the telephone contact she had with the man and subsequently with Brixton on 28 September. She said that it was normal for the man to be up and down about his situation, but that on 28 September he had sounded different to her. She became concerned for his wellbeing. She said that he had sworn on God in one of the calls, which is something he never did. He had been crying and told her that he loved her and could not live without her any longer. She told him that she loved him and that they had to be strong together and she needed him in her life. She said that he cried at just hearing her voice and he was worried because he did not know how long his sentence was gong to be and thought he might not be able to complete his sentence. He told her to move on but she refused and told him she would wait for him. He also said 'goodbye' and 'farewell', something he had never said before.

50. She said she was so worried about him that she telephoned Brixton at around 4.00pm to tell them about her concerns. They said they would

phone her back. She phoned back at 5.00pm as she had not heard from them. She said that the person who answered the phone that time shouted at her and was extremely unhelpful. The investigation team has not identified the person who spoke to his partner on that occasion. The man's partner did not use the prison 'at risk' telephone number so the calls were not recorded. She felt that Brixton did not take her concerns seriously and took her warnings as a joke. She said that she was very upset when she telephoned Brixton and cried and begged them just to watch the man.

51. The Duty Governor on 28 September 2004 took the first telephone call from the man's partner. He said that he had just finished a meeting (probably a suicide prevention team meeting) at around 3.30pm and he received a call from somebody who said she was worried about her boyfriend who seemed suicidal and she was concerned that he might 'do something silly'. He could not recall the exact wording she used. He asked her to give him some details, which she did. She told him her boyfriend's name, gave his prison number, and said that he was located on A wing. He told her that he would get in touch with A Wing and the matter would be taken forward from there. He said that she seemed to be quite happy with that. It seems that the man's partner was expecting a call back after this telephone call but there is no record of her telephone number in the Duty Governor's notes of the telephone call.

52. The Duty Governor said that he immediately phoned A Wing after this telephone call and spoke to another officer on A Wing, Officer D. He said that he told Officer D to get the Senior Officer on A Wing to talk to the man, to get the man's details and his prison number and when he had assessed the situation to ring him back. He said that he phoned A Wing again at about 4.00pm and spoke to Senior Officer C. Senior Officer C told him that he had passed this message on to another Senior Officer on duty, Senior Officer B.

53. Senior Officer B went to talk to the man at around 4.00pm after he had co-ordinated the wing for the serving of tea. He said that he went into the man's cell and told him that there had been a telephone call from somebody outside the prison who was concerned about him. Senior Officer B did not know the name of the person who had called at that point. He asked the man how he was feeling and the man said that he felt fine, that there was nothing wrong with him at all. He said that he did not know anybody who would phone up from outside, that he did not have any relatives close by. Senior Officer B asked the man about his relatives and the man said that his father had left his mother and his mother had moved away and he did not have any contact with them. He said he could not think who would be phoning up about him. Senior officer B discussed his living circumstances and explained to him how to apply to keep the tenancy of his council flat. Senior Officer B left feeling that there was no problem with the man.

54. Senior Officer B then spoke to Senior Officer A, who confirmed that she had also spoken to the man and she agreed that he seemed fine. She said that she had spoken to him because his cellmate was very concerned about him. Senior Officer B then went back into the cell to speak to the man again, because of what Senior Officer A told him about the cellmate's concerns. He spoke to the man for around 15 minutes. They chatted generally about Bengal. He said that there was no evidence that the man had been crying and he had no concerns about him after their conversation. He said at interview that he did recall that prisoner A had mentioned concerns about the man and he told him that he had spoken to the man and he was fine. He said that he did not consider putting another prisoner in the cell with the man as he had absolutely no concerns about his wellbeing. He did not give any instructions to staff working on A Wing in respect of the man. He discussed the man with Senior Officer A after this second conversation with him and they both felt that he was fine. This is confirmed by Senior Officer A as detailed above.

55. Senior Officer B wrote in the Wing Observation Book as follows, 'We received a call from Victor 3 who in turn had received a call from an outside party voicing concern over harming himself. Myself and Senior Officer A have spoken to him separately and both of us have no concerns. He has assured both of us that he is fine and he states he has no thoughts of self harm.'

56. The Duty Governor spoke to Senior Officer B around 5.15pm. Senior Officer B confirmed that he had spoken to the man, and that he did not consider he was suicidal.

57. Senior Officer C also spoke to Senior Officer B when he returned from talking to the man. Senior Officer B told him that the man did not know who had phoned up, did not recognise the person's name and said that he was fine. Senior Officer C phoned the Duty Governor and gave him that information and the Duty Governor confirmed that he had already spoken to Senior Officer B. Senior Officer C told the Duty Governor that he was going to talk to another prisoner on A Wing with the same surname as the man just in case the telephone call was relating to him.

58. It is not clear whether the Duty Governor was aware of the concerns expressed to Senior Officer A by prisoners about the man's wellbeing. The Duty Governor did not phone the man's partner to let her know the outcome of Senior Officer B's conversation with the man.

59. The Suicide Prevention Officer, said that she did not know about the telephone calls from the man's partner until three days later. She explained that the man's partner did not use the 'at risk hotline', which prisoners' family and friends can phone if they have concerns about a prisoner, and which she monitors. There is no record that these calls had been received on the hotline and they must have come through the main switchboard. This means that they would have been received directly by either the Duty Governor or the Orderly Officer to deal with. The suicide

prevention officer said that as the telephone calls did not come through the at risk helpline she would not necessarily have been included in this. She said that she would probably not have become aware that a call had been received until checking the Wing Observation Book the following day, if an entry had been made. No mention about the man had been made to her directly as a result of the telephone calls from his partner.

Events on the evening of 28 September

60. As noted earlier in this report, the man's cellmate, had left the prison early in the morning of the 28 September to attend Court. During the afternoon of 28 September, before the cellmate returned to Brixton, the prison held a Suicide Prevention Team Meeting. There is no note in the minutes of that meeting of any discussion relating to either the cellmate or the man. The Suicide Prevention Officer, said that the incident with the cellmate had been discussed at this meeting and that it was agreed that the cellmate would be relocated to Healthcare on his return from court that evening. No member of A Wing staff attended this meeting.

61. Senior Officer B was the Senior Officer in charge of A wing on the evening of 28 September when the cellmate returned from his court appearance. He said that he would have been made aware of the incident involving the cellmate during the early hours of that morning. He was not, however, aware of any decision to relocate the cellmate to Healthcare on his return from court, as apparently decided during the Suicide Prevention Team meeting earlier the same day.

62. An officer on the wing, Officer E, was on a training course for most of 28 September, and he returned to duty on the wing at around 4.30pm. His role then was to manage the wing movement desk - that is, to receive prisoners from reception and allocate them to cells within the wing. He said an officer from reception brought the cellmate back to A wing following his court appearance and the cellmate asked to be located back in his old cell, A2-03. That cell was available at the time so he asked another officer, Officer F, to locate the cellmate there. As far as he was aware, Officer F locked the cellmate back into his previous cell. He said that he was not aware that the cellmate had tried to hang himself early that morning, and he had not been given any instruction to locate him in Healthcare.

63. Officer F did indeed escort the cellmate back to his old cell. Officer F, too, was not aware of the decision of the Suicide Prevention Team meeting to locate the cellmate in Healthcare. There is a question as to whether, before the cellmate was allowed to enter the cell, Officer F looked through the door observation panel to see what might confront them on opening the door.

64. The cellmate said that, when he returned from court to Brixton, he was told that he was to return to the cell where the man was located. When he returned there the cell was dark and he could not see the man. He lit a

cigarette, turned on the light and saw the man hanging by a ligature attached to the cell window bars. He ran to the door and called for the staff to help. Three or four minutes later a member of staff came to the cell.

65. Senior Officer B said that he had been standing on the first floor landing when at around 6.50pm he heard banging from the landing above. He ran upstairs to see where the banging was coming from. He opened the cell door and found the cellmate crying and shouting, in total shock. The cellmate came out of the cell and Senior Officer B saw the man hanging. Officer F entered the cell behind him. Senior Officer B could not remember whether he personally shouted for a Code 1 emergency at that stage. The Code 1 call is logged at 6:51pm. Officer F supported the man and cut the ligature. He thought he might have then shouted for a Code 1 emergency, although this could have been done automatically by another member of staff as he recalled that the healthcare response was very quick. Senior Officer B said that Officer F tried to resuscitate the man until healthcare staff arrived.

66. Brixton's Protocol for Medical Response Codes describes a Code 1 emergency as: life threatening conditions (e.g hanging (unresponsive), severe chest pain, heart attack, severe bleeding, no pulse or breathing). A code 1 emergency was called in this case. Healthcare staff carry out the roles of Hotel 6 and Hotel 3 in responding to medical emergencies as described in the protocol. Hotel 6 is first on call for medical emergencies and should proceed immediately to the site of the emergency to assess the patient and start basic life support. Hotel 3 should also respond as quickly as possible, to take over the co-ordination of the scene.

67. The Contingency Orders for dealing with an attempted suicide, serious injury or an apparent death of a prisoner, state that officers discovering the incident should take the emergency equipment (ambu bag equipment) from its agreed area of storage on the wing to the emergency. Officers should then carry out emergency help and first aid while waiting for healthcare staff to arrive, including resuscitation if there are no signs of breathing.

68. Although it is not mentioned in the Protocol for Medical Response Codes, the full resuscitation equipment bag is located in the healthcare wing and it is understood by healthcare staff that Hotel 3 is also responsible for bringing that equipment from the healthcare wing to the emergency.

69. The investigation team was not able to interview Officer F because he was absent on long-term sickness. A memo he submitted after the incident confirmed that, when the cellmate returned from his court appearance he located him in cell A2-03, with the man. He confirmed the events that followed as detailed by Senior Officer B and that he attempted to resuscitate the man.

70. Officer E, said that about five seconds after the cellmate was put into the cell he heard a lot of banging and screaming coming from the cell. He saw that Officer F was already on the landing and Senior Officer B walked up the stairs to the cell. Officer E said he followed closely behind Senior Officer B, Senior Officer B opened the door and the cellmate came out of the cell. The cellmate was very distressed and was crying. Senior Officer B turned the cell light on and Officer F followed him into the cell. They saw the man hanging. Senior Officer B supported his body and Officer F cut the ligature. Officer E said he did not enter the cell himself as there was no room. He made a call to the Communications Room informing them of a Code 1 incident and called another officer to deal with other prisoners who were trying to get into the cell to see what had happened. The cellmate was taken to the Listener's room and Officer E asked a prisoner who was training to be a Listener, to look after the cellmate until a trained Listener arrived.

71. A Senior Officer on A Wing, Senior Officer D, was carrying out the duties of Assistant Orderly Officer that night. He said he responded immediately to the emergency call and he saw Officer F in the cell and the man lying on the floor. Senior Officer D was not sure whether Officer F had carried out any CPR and there were no nursing staff on the scene. He heard later that CPR had been carried out but, as staff believed life had expired, they stopped administering it. Medical staff, the doctor and a Principal Officer carrying out duties as an Orderly Officer, arrived later.

72. A Senior Officer on B Wing, Senior Officer E, heard the alarm call over the radio and made his way to A Wing and was directed to the incident. He said he arrived at practically the same time as Senior Officer D and saw the man lying on the floor. Senior Officer B and Officer F were in the cell. They said they thought the man was dead. He, too, did not recall seeing any CPR being carried out at this stage. He checked with the Emergency Control Room whether the ambulance was on its way and was told that it was. On the way back to the incident he saw a nurse on her way up the stairs, Nurse A. He told her that she would need an ambu bag so he went into the office on A Wing and with a little difficulty found the ambu bag. The nurse took the ambu bag and carried on upstairs.

73. Nurse A covered emergency response duties on 28 September (call sign Hotel 6). She confirms the account given by Senior Officer E. She was the first member of healthcare on the scene. She said she received a Code 1 emergency call to A Wing and ran to the wing. When she got to the stairs she saw Senior Officer E and asked him what the problem was. He said there had been a hanging and confirmed there was no ambu bag at the scene. She went to the wing office where the ambu bag should have been, but could not locate it there. Senior Officer E helped her to look for the ambu bag and said that he would look in the office next door. She then telephoned her colleague, Nurse B, to attend the scene. She then went to the cell and saw two officers there. She could not remember whether either of the officers had been carrying out CPR at the time she arrived. The ambu bag was located in the second office and arrived at the

cell shortly after. Seconds after Nurse A entered the cell, Nurse B arrived and together they checked the man's vital signs and commenced CPR. They concluded there was no sign of life and the doctor arrived shortly after.

74. Nurse B confirmed he received the call from Nurse A to attend the scene. He asked if another Nurse, Nurse C (call sign Hotel 3) had arrived on the scene yet and was told he had not. He therefore asked staff to make sure the ambu bag was there. He telephoned D Wing where Nurse C answered almost immediately. He told him there was a hanging on A Wing and that they needed the full resuscitation kit and ambu bag there. Nurse B then ran straight across to A Wing and arrived at the scene around 6:53. He saw the man lying on the floor, and Nurse A was in the cell. Nurse B said that he arrived in the cell around 6:53 and the man felt cold as though he had been dead for some time. He did not see any CPR being carried out when he arrived. He could not find any signs of life. He commenced the basic process of clearing the man's airway. There were no signs of breathing. He described in detail how he attempted to resuscitate the man with Nurse A. He said that Nurse A gave external chest compressions and that they both continued that at a rate of 15 compressions to two breaths. They started CPR at around 6.55pm, within four minutes of the initial emergency call. When Nurse C arrived, Nurse A told him to call the duty doctor urgently. The doctor arrived within a few minutes. Nurse B continued CPR with Nurse A while the doctor assessed the situation. They then took a break from CPR for the doctor to examine the man. The doctor pronounced the man dead at 7.04pm. The man had been given nine minutes of CPR.

75. In Nurse B's opinion the delay in Nurse C and the equipment arriving had not caused a detriment to the man's treatment. He said that in this case, he did not think that it would have made any difference to the man's survival if the equipment and Nurse C had arrived earlier. However, it could make a difference in another case.

76. Nurse C was Hotel 3 Nurse on 28 August. He said that he responded immediately to the emergency call and made his way to collect the resuscitation bag. As he was leaving, he answered a telephone call from Nurse B asking him to attend the scene as quickly as possible. He told Nurse B that he had been on his way to the scene when he was called back to answer his phone call. The Investigation Team noted that the member of staff who undertakes this role (Hotel 3) is not provided with a radio.

77. An officer, Officer G, was working in healthcare on 28 September. He said in a memo that he was sitting in the landing office with Nurse C when Nurse C received the Code 1 emergency call. He said that Nurse C did not make any effort to move when the call came through. It was not until Nurse C answered the telephone call asking him to go immediately to the scene that he collected the emergency resuscitation equipment and left

the office to go to the incident. This contradicts the account given by Nurse C.

78. The Duty Governor, said that there was no doctor present when he arrived at the scene shortly after 6:54pm and the man's body was covered with a sheet, apart from his feet. He said that he did not see CPR taking place.

79. A Principal Officer, was undertaking Orderly Officer (Oscar 1) duties in the prison. She confirmed that when she attended the incident she saw the Duty Governor coming down the stairs and he told her that the man was dead. Shortly after that, a doctor arrived and she directed him to the incident. She saw a male nurse meet the doctor at the entrance to the cell. She then looked in the cell and saw that the man's body was covered with a quilt.

80. The prison's incident report did not mention any prisoner witnesses but the investigation team discovered that three prisoners (Prisoner D, Prisoner E and Prisoner F) said they were present and had evidence relevant to the investigation. Prisoner D, who at the time of the incident was training to be a Listener, said that it was clear to him, before the incident, that the man was depressed. He said that the man only came out of his cell for his dinner. He had introduced himself to the man and told him he could talk to him at any time but the man never spoke to him. On the night of the incident he heard loud banging on a cell door. He then saw Senior Officer B run up the stairs and heard a cell door being opened. Senior Officer B shouted for A Wing to be locked down. He thought there must have been a self harm incident so he ran up the stairs with towels and followed Senior Officer B into the cell. He cannot remember much after that but recalls that he saw the cellmate on the floor, shouting and screaming, and that Senior Officer B cut the man down. Prisoner D then took the cellmate to the Listener's suite and stayed with him until a trained listener arrived.

81. Prisoner E and Prisoner F returned from court at the same time as the cellmate. Prisoner E said that he heard banging coming from the man's cell and he saw Senior Officer B entering the cell and the cellmate immediately came running out of the cell. Prisoner E said that Senior Officer B ran into the cell and he ran in after him where he saw the man hanging with a ligature tied to the cell window bars. Officer F then came into the cell and ushered him out. He started vomiting outside the cell and shortly after an officer locked him into a cell.

82. Prisoner F said that he saw Officer E unlock the man's cell and saw the man hanging in the cell. Officer E then radioed for assistance and tried to clear the landing of prisoners. He said there was a delay in cutting the man down. He is the only witness to mention this. He also said that some prisoners did not move back to their cells so he tried to help Officer E to deal with this. He was then locked back in his cell.

83. These prisoner witnesses were not asked to confirm whether CPR was administered to the man while they were observing the incident.

84. A doctor employed by Brixton as a locum doctor at the time of the incident pronounced life extinct. He refused to be interviewed on the advice of the Medical Defence Union. The investigation has found that the doctor did not complete the relevant paperwork following the man's death. That is, he did not adequately document the actions he took or his final diagnosis of the man's death. He is no longer employed by Brixton.

The note left by the man

85. The man left a note in which he said, 'No one is responsible for my death. No one is to blame. I sincerely apologise for lying to the officers on the landing. I lied because this is not a cry for help. No one can help me. I just want the pain to stop and the only way is death. I simply want to be at peace.'

CLINICAL REVIEW

86. Lambeth Primary Care Trust (PCT) is responsible for the provision of health care services in Brixton. In accordance with procedures agreed with the NHS, the investigation team advised the PCT of the man's death. The PCT then arranged to undertake a clinical review of the healthcare provided to the man while at Brixton. A doctor undertook the review.

87. The doctor's report is attached, and makes a number of recommendations. The clinical review looked at issues relating to management of the prison, rather than just clinical matters, and there is therefore some duplication with my own investigation. There is also some overlap between some of the clinical review recommendations and my own conclusions and recommendations.

CONSIDERATION AND CONCLUSIONS

88. The man was received into Pentonville on 17 August 2004. There were no concerns of self-harm or suicidal thoughts raised through the PER. He said that he had attempted suicide four years previously and that he had been taking anti-depressant medication which he had stopped taking, and he did not want to be prescribed that medication again. He was described by the doctor as being 'in low mood' and prescribed a once only prescription of medication to help him sleep. This is not uncommon for a prisoner received into prison and this in itself would not normally require an increase in that prisoner's level of supervision. Neither the healthcare worker nor the doctor felt that the man was at risk of self harm or experiencing suicidal thoughts, and it was not felt necessary for the prison to contact his medical practitioner to obtain a current medical/mental health history. This information was available to Brixton when the man arrived there. He was found to be fit and well and was placed on normal location. As with Pentonville, no effort was made by Brixton to contact the man's medical practitioner to obtain information about his current medical/mental health. Information and Practice (IAP) 1/2002 clearly

states that efforts should be made by the prison to obtain previous information about a prisoner's medical history. In view of the man's previous history of depression, I judge that Brixton should have carried out a more thorough medical examination on reception, including obtaining information from the man's GP and immediately referring him for a mental health assessment.

Recommendation: The Primary Care Trusts for Brixton (Lambeth PCT) and Pentonville (Islington PCT), in partnership with those prisons, should be asked to develop a policy for ensuring a prisoner's past medical history is obtained in a timely manner.

Recommendation: The Primary Care Trusts for Brixton (Lambeth PCT) and Pentonville (Islington PCT), in partnership with those prisons should be asked to ensure that those prisoners with an identified mental health history receive a timely and appropriate mental health assessment, in order to formulate an appropriate multi-disciplinary plan of care.

89. It is clear that there was a strong group of Bengali prisoners on A Wing, where the man was located. This group attempted to engage with the man and to support him during his time in custody. It appears from the conversations with his partner that he had some concerns about the length of the sentence he would receive but he did not raise these concerns with staff. No evidence was found to indicate that the man was the victim of bullying while on A Wing or that he had sought any medical help for his previously reported depression.

90. During the early hours of the morning of 28 September, the man's cellmate attempted to commit suicide by hanging. It is clear that the man's quick action at the time played a crucial part in saving the cellmate's life. Night staff responded to this incident quickly and both the man and the cellmate were taken out of the cell and received some support. The man spoke to Officer A after the incident and Officer A asked him if he wanted to talk to anybody else, which he declined. The Orderly Officer, together with medical staff spoke to the cellmate and he was placed on a F2052SH. Both men were then located back to the same cell.

91. The support that the man received immediately after the incident therefore appears to have been adequate and he was offered the opportunity to speak to somebody. However, it is not clear whether it was explained to him that he could talk to a prison Listener or the Samaritans. Also no consideration appears to have been given to placing the man on a F2052SH form. The men were located back to the same cell after what must have been a very traumatic experience for both of them.

92. Officer A used the Wing Observation Book as a means of communicating to staff who came on duty the next morning about what had happened. However, the entry in the Observation Book was lacking as it did not fully mention the role the man played in the incident with the cellmate. When staff

came on duty for the main day shift on 28 September, at around 7.45am, most of them became aware of the incident with the cellmate, but there was confusion in respect of further support for the man.

93. The wing manager, Senior Officer B, thought that, as the man had been offered the services of Listeners and declined this, there was no need to offer further support. The suicide prevention co-ordinator, said that further support should have been offered by the wing manager. No further support was offered to the man and he was located back to the same cell with the cellmate. Of course he could have asked for help at any time, but considering the role he had in assisting the cellmate, staff should have been more proactive in supporting him. There was a clear lack of co-ordination between managers, with the assumption that others would support him. In fact, the man was initially left alone in his cell when the cellmate went to Court later that morning.

Recommendation: **The Governor should remind staff that entries in Wing Observation Books must be worded to enable effective communication between Wing staff on hand over between shifts or that a proper oral hand over is undertaken between shifts.**

94. When the cellmate went to court on the morning of 28 September, arrangements were eventually made for a Bengali prisoner, prisoner B, to move into the cell with the man. When prisoner B was moving into the cell, he said that the man told him that he was going to hang himself. Prisoner B immediately approached other Bengali prisoners on A Wing, prisoner A prisoner C and they went to speak to the man. Prisoner C said that he recovered a razor blade from the man's cell and gave it to Senior Officer A. These prisoners are adamant that they told Senior Officer A about their concerns as to the man's intentions and that they were worried that he might kill himself. The police investigation has not been able to establish whether a razor blade was recovered from the man's cell bin. The man clearly did not want to be left alone in his cell and I commend the action of the prisoners in trying to ensure this did not happen and raising their concerns with staff.

95. These prisoners describe Senior Officer A's reaction to their concern as dismissive and non-caring. It seems there may have been some confusion about the incident with the cellmate. The fact that a number of prisoners approached Senior Officer A with concerns might have led her to open an F25052SH or at least ensured that the man was not left alone in his cell.

96. Senior Officer A denies that any prisoner showed her a razor blade. She said that she decided to speak to the man as a result of the concerns of the prisoners and found him to be fine. I do not doubt this to be the case but it is surprising in light of the telephone conversations the man had with his girlfriend later on. The allegation that Senior Officer A did not take any action in respect of the razor blade is a serious one. However, in light of her denial and the fact that the police could not say if the razor blade was recovered from the man's cell, I do not believe that this is a matter that can be taken further.

97. The man telephoned his partner several times during the afternoon of 28 September. It is clear from these telephone calls that he was in an extremely distressed state. He appears to have convinced himself that the relationship was over or was rapidly deteriorating. His partner was very worried after these telephone calls and she phoned Brixton twice to express her concerns. She did not use the 'at risk' hotline and it is unclear whether she knew the number for it. The Duty Governor confirms that he took one of those telephone calls. The man's partner was expecting the prison to phone her back but the Duty Governor did not make a note of her telephone number when he took the call. In response to the telephone call and concerns raised by the man's partner, the Duty Governor contacted A Wing and asked for the Senior Officer to talk to the man to assess the situation and to report back to him. I consider this action was correct and appropriate.

98. Senior Officer B went to the man's cell and spoke to him at length. The man told him that he did not know the person who had phoned and appeared to be fine. Senior Officer B then spoke to Senior Officer A who told him about the prisoners' concerns for the man. He then went back into the man's cell to talk to him again. He was again satisfied that the man was fine.

99. I accept that, following these conversations, Senior Officer B was content that the man was alright. However, basic precautionary measures were not taken at this stage. Information had been received from two independent sources (the man's partner and prisoners) that the man intended to harm himself. Senior Officer B had a number of options for action he could have take

- He could have implemented F2052SH monitoring procedures.
- He could have arranged for the man to be seen by the establishment's doctor or other medical staff on duty.
- He could have offered the man the services of a Listener.
- He could have issued instructions for the landing staff to conduct regular watches on the man over a short period, as happened the previous morning.
- He could have ensured that the man was located with another prisoner.

100. None of the above actions were taken. The man acknowledged in his suicide note that he was determined to kill himself and no one was responsible for his death. However, given the warnings received from two different sources it is difficult to avoid the conclusion that preventative action should have been taken.

Recommendation: A training needs analysis should be carried out to cover training in suicide awareness, risk assessment and prevention.

101. I commend the use of the 'at risk' hotline for concerned relatives and friends. However, this system could be improved if calls were answered personally rather than by an answer machine. In this case it was not used. It would have been good practice for the Duty Governor to have phoned the

man's partner back after enquiries had been undertaken following her call. This might have prompted the man's partner to express further concern if she had been told that the man was denying that he knew her. The Duty Governor could also have made sure that she knew the telephone number for the 'at risk' hotline.

Recommendation: The Governor should remind staff that, when issues of concern are expressed by families or friends of prisoners, the prison should relay the result of any subsequent enquiries to the concerned family member or friend.

102. A number of initiatives have been implemented at Brixton's to reduce the risks of both self harm and suicide. I note, however, that the Suicide Prevention Officer's post is a singleton post and it is not clear who has the responsibility for covering the duties of this post when the officer is absent.

Recommendation: The Governor should review arrangements to provide cover for the Suicide Prevention Officer when that officer is absent.

103. There was a Suicide Prevention Team Meeting during the afternoon of 28 September. It appears the incident with the cellmate was discussed at that meeting and that it was agreed that the cellmate should be relocated to Healthcare on his return to Brixton that evening. This was a sound decision particularly as the cellmate was concerned about what sentence he would receive. It seems that the team took responsibility to make sure this happened. Despite this, there is no record of this decision in the minutes of the meeting and in fact the cellmate was not relocated to Healthcare. He was returned to the cell with the man. A prisoner who arrived back from Court with the cellmate said that the cellmate was depressed when he came back from Court. It is clear that there was a breakdown in communication. This not only failed to locate the cellmate to Healthcare on his return from Court but also ended with him being relocated back into the same cell as the man.

Recommendation: **The Governor should remind members of the Suicide Prevention Team that actions recommended in meetings should be clearly minuted and conveyed to relevant staff.**

104. The cellmate called staff to help when he discovered the man suspended in the cell at 6:50. Officer F and Senior Officer B say that they responded to the incident and entered the cell without delay at 6.51, that the man was supported and the ligature was removed. It appears that CPR was then started by Officer F and continued until medical staff arrived at which point they took over. They make no mention of any prisoners in the vicinity at the time. According to prisoner witnesses this was not the case. Two prisoners said that they actually went into the cell when the man was discovered and another says that there was a delay in cutting the man down.

105. I have been unable to conclude which version of events is correct. I accept that staff attended the incident and that medical staff were called to assist almost immediately. Officer F has said that CPR was commenced and

continued until medical staff arrived. Senior Officer B cannot recall whether CPR was definitely undertaken by Officer F. Likewise, neither Senior Officer D or Senior Officer E, Senior Officers who arrived at the scene before the medical staff, are able to confirm that CPR had commenced and was ongoing. This is particularly relevant as Nurse Ai (Hotel 6) said that she tried to obtain the ambu bag and other equipment from the wing office before she went to the incident. There was further delay as she made a telephone call to Nurse B (Hotel 3) in reception, to ask him to attend the incident. It is not clear whether CPR was ongoing during this time. Nurse A said that she did not recall CPR being carried out when she entered the cell.

106. Nurse B also said that he did not see CPR being carried out when he arrived on the scene. There is no doubt that CPR was started immediately when healthcare staff arrived and that every effort was made to revive the man. However, a significant amount of time could have been lost before CPR was commenced.

107. Another concern is that the man was clearly covered by a sheet or a quilt before the doctor arrived. This was confirmed by the Duty Governor, who says that he arrived at the scene shortly after 6.54. This was also confirmed by the Principal Officer who arrived at the scene just after the Duty Governor, and by the doctor himself. If this is the case it would suggest that CPR had definitely been stopped before the doctor arrived and declared life extinct. However, this evidence is contrary to what was said by the nurses who attended.

108. It is impossible to know exactly what happened during the incident and whether CPR was commenced at the earliest opportunity and continued, as there are many contradictions in incident statements. However, I have concern in respect of the response from Hotel 3 (Mr C) and his alleged delay in responding to the incident as explained by another member of staff. It is not clear whether, if the resuscitation equipment had arrived earlier, it would have made any significant difference in this case because when it was delivered it was not actually used. What is of concern is that it could make all the difference in a future incident.

Recommendation: I acknowledge that the accounts given by officer G Nurse C are contradictory. However, the Governor, in partnership with Lambeth PCT, may wish to consider undertaking his own inquiries into the matter as another member of staff has said that Nurse C did not respond immediately to the code 1 alert on 28 September 2004 when carrying out Hotel 3 duties.

Recommendation: The Healthcare Manager/Lambeth PCT should review the training of healthcare staff and issue guidance regarding their responsibility and the authority they hold when responding to medical emergencies. This should include all protocols in place for dealing with prisoners who are suspected to have attempted suicide.

Recommendation: The Governor should ask his Healthcare manager to

ensure that ambu bags are appropriately located within the prison and that relevant staff are aware of their location to make sure they are brought to the scene at the earliest opportunity.

Recommendation: A training needs analysis should be conducted to cover the issues raised in this report in respect of first officer at the scene of a serious incident. This should include procedures while awaiting the arrival of healthcare staff, as well as emergency resuscitation procedures to be carried out.

109. Nurse B was not given a radio when covering Hotel 3 duties and this could have contributed to the delay in his response to the incident as he had to be telephoned to respond. At a time when there is reduced medical cover it is unacceptable that available medical staff are not provided with radios to enable their assistance to be requested much easier.

110. Two instruction documents are in use by the prison which explain to healthcare staff and discipline staff how to deal with medical emergencies. These are a Protocol for Medical Response Codes and Contingency orders for dealing with an attempted suicide, serious injury or an apparent death of a prisoner. These instructions do not fully correspond with each other and do not contain a full description of the role of Hotel 3 and Hotel 6, particularly in respect of ensuring that the full emergency resuscitation equipment is brought to the scene.

Recommendation: The Governor should consider the feasibility of issuing all Healthcare staff with radios during evening duty periods and at other times when medical staffing numbers are reduced. This should be supported by issuing revised guidance for healthcare and discipline staff to detail the role of Hotel 3 and Hotel 6 in responding to a medical emergency.

111. A doctor employed by Brixton as a locum doctor at the time of the incident is no longer employed by the establishment. On the advice of the Medical Defence Union he refused to be interviewed for this investigation. He pronounced life extinct but did not complete the relevant paperwork as he failed to note any action taken or his final diagnosis.

Recommendation: A copy of the report should be sent to Lambeth PCT with a view to their considering undertaking their own investigation into the failure of the doctor to appropriately complete medical records in accordance with the requirements of the General Medical Council (GMC).

112. All concerns within the clinical review have been addressed apart from the issue of healthcare staff not being trained in emergency resuscitation procedures beyond the use of an airway and then ambu bag ventilation. The clinical review recommends that consideration be given to training all healthcare staff in emergency intubation procedures after incidents resulting in possible airway collapse or obstruction**.** Whilst it is not considered

appropriate to train staff in emergency intubation, consideration should be give to all healthcare staff being trained in CPR and the use of Automatic External Defibrillators.

Recommendation: **The Healthcare Manager/Lambeth PCT should consider training all healthcare staff in CPR and the use of Automatic External Defibrillators.**

RECOMMENDATIONS

ESTABLISHMENT:

1. Recommendation: **The Governor should remind staff that entries in Wing Observation Books must be worded to enable effective communication between Wing staff on hand over between shifts or that a proper oral hand over is undertaken between shifts.**

2. Recommendation: A training needs analysis should be carried out to cover training in suicide awareness, risk assessment and prevention.

3. Recommendation: The Governor should remind staff that, when issues of concern are expressed by families or friends of prisoners, the prison should relay the result of any subsequent enquiries to the concerned family member or friend.

4. Recommendation: The Governor review arrangements to provide cover for the Suicide Prevention Officer role when that officer is absent.

5. Recommendation: The Governor should remind members of the Suicide Prevention Team that actions recommended in meetings should be clearly minuted and conveyed to relevant staff.

6. Recommendation: I acknowledge that the accounts given by Officer G and Nurse C are contradictory. However, the Governor, in partnership with Lambeth PCT, may wish to consider undertaking his own inquiries into the matter as another member of staff has said that Nurse C did not respond immediately to the code 1 alert on 28 September 2004 when carrying out Hotel 3 duties.

7. Recommendation: A training needs analysis should be conducted to cover the issues raised in this report in respect of first officer at the scene of a serious incident. This should include procedures while awaiting the arrival of healthcare staff, as well as emergency resuscitation procedures to be carried out.

8. Recommendation: The Governor should consider the feasibility of issuing all Healthcare staff with radios during evening duty periods and at other times when medical staffing numbers are reduced. This should be supported by issuing revised guidance for healthcare and discipline staff to fully detail the role of Hotel 3 and Hotel 6 in responding to a

medical emergency.

HEALTHCARE:

9. Recommendation: The Primary Care Trusts for Brixton (Lambeth PCT) and Pentonville (Islington PCT), in partnership with those prisons, should be asked to develop a policy for ensuring a prisoner's past medical history is obtained in a timely manner.

10. Recommendation: The Primary Care Trusts for Brixton (Lambeth PCT) and Pentonville (Islington PCT), in partnership with those prisons should be asked to ensure that those prisoners with an identified mental health history receive a timely and appropriate mental health assessment, in order to formulate an appropriate multi-disciplinary plan of care.

11. Recommendation: The Healthcare Manager/Lambeth PCT should review the training of healthcare staff and issue guidance regarding their responsibility and the authority they hold when responding to medical emergencies. This should include all protocols in place for dealing with prisoners who are suspected to have attempted suicide.

12. Recommendation: The Governor should ask his Healthcare manager to ensure that ambu bags are appropriately located within the prison and that relevant staff are aware of their location to make sure they are brought to the scene at the earliest opportunity.

13. Recommendation: A copy of the report should be sent to Lambeth PCT with a view to their undertaking their own investigation into the failure of the doctor to appropriately complete medical records in accordance with the requirements of the General Medical Council (GMC).

14. Recommendation: The Healthcare Manager/Lambeth PCT should consider training all healthcare staff in CPR and the use of Automatic External Defibrillators.