

**Investigation into the circumstances surrounding the
death of a man
at HMP Brixton on 27 February 2007**

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

May 2008

This is a report of an investigation into the circumstances of the death of a man at HMP Brixton on 27 February 2007. The man was found hanging from the bars of his window when an officer opened his cell for lunch shortly before noon. Despite staff attempts at cardiopulmonary resuscitation and the attendance of paramedics, he could not be revived. The man had been remanded in custody five days earlier. He was 51 years old.

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

The investigation was carried out on my behalf by my colleague, Mrs Ruth Houston. A clinical review of the man's healthcare at HMP Brixton is being carried out by Lambeth Primary Care Trust but, to date, it has not been completed.

I would like to thank the Governor of Brixton, and his staff for their co-operation and assistance. Particular thanks go to the prison's liaison officer, for his help throughout the investigation process.

When the man arrived at Brixton, he had already served 12 years of a life sentence. At the age of 51, he faced the possibility of a second life sentence and the prospect of spending most of the rest of his life in prison. In a letter he wrote on the morning of his death, he described his unwillingness to outlive the former partner he was accused of killing.

Although I have identified two failures in Brixton's procedures, it is clear that the man gave staff no concern for his welfare. I make two recommendations designed to address those failures.

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Prisons and Probation Ombudsman

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SUMMARY

The man died on 27 February 2007 in his cell at HMP Brixton. He had been sentenced to life imprisonment for the murder of his wife but in 2005, he absconded from an open prison. On 22 February 2007, he was remanded in custody and charged with the murder of a former partner with whom he had a relationship during his two years unlawfully at large.

When he arrived at Brixton, the man was seen by the duty nurse in reception who completed the first reception health screen. During the process, the man mentioned problems with his right knee but denied any thoughts of harming himself. In view of the offence with which he had been charged, the nurse should have automatically referred the man for a mental health assessment. However, she was unaware that the man had been charged with murder and did not make the referral.

The following day (23 February), the man was classified as a potential category A prisoner and placed on hourly observations. He was also moved to a single cell. On the afternoon of 26 February, he was informed that he had been given category A status and would be transferred to HMP Belmarsh as soon as possible.

Staff on the wings were very busy on the following morning. As a category A prisoner, he was subject to hourly checks, but there is no record of any checks on him after 10.00am.

Just before noon, an officer unlocked the man for lunch and discovered him hanging from the window bars at the back of the cell. Both officers and healthcare staff tried unsuccessfully to resuscitate the man. Ambulance paramedics also attended but nothing more could be done. A prison doctor certified his death at 2.33pm.

On arrival at Brixton, the man had given no information about next-of-kin. As a consequence, staff had great difficulty in trying to obtain contact details after his death. Unfortunately, whilst attempts were still being made to trace his relatives, members of the family learned of the man's death from newspaper reports.

THE INVESTIGATION PROCESS

1. My investigator visited HMP Brixton on 1 March to open the investigation. She met senior managers, as well as representatives of the Independent Monitoring Board and Prison Officers' Association. She also saw the man's cell and walked around the first night centre.
2. The investigator returned a number of times to interview staff who had talked to the man during his time in prison and those who had attempted to resuscitate him.
3. One of my Family Liaison Officers wrote to the man's family to ask if they wished to raise any concerns. The family did not respond.

I commissioned a clinical review from Lambeth Primary Care Trust. The report of the review is not yet available. I expect it to be completed within the next few weeks and the findings will be included in my final report.

HMP BRIXTON

4. Brixton's original buildings date from 1819. In 1898, they were enlarged and improved and the prison became the trial and remand prison for the whole of the London area.
5. The prison now serves the local magistrates' courts and Inner London and Southwark Crown Courts. It holds remand and sentenced prisoners committed from these courts. Convicted prisoners have an initial interview and are then categorised and allocated to another prison with facilities appropriate to that sentence and the prisoner's needs.
6. Brixton holds 800 men in four main residential units and a healthcare wing. During the man's time at the prison, the induction unit was on G wing. It has now been located on C wing.

KEY FINDINGS

7. The man arrived at Brixton on the evening of Thursday 22 February 2007. He was seen in reception by an officer who completed the Personal Summary Sheet. The man said that he was of no fixed abode and gave no name or contact details for his next of kin. The reception officer noted that the man was suffering from pain in his right leg.
8. The staff nurse then interviewed the man and completed the First Reception Health Screen form. This is an assessment of a prisoner's physical and mental health and any substance misuse problems. The information entered on the form is obtained from other documents and from what the prisoner himself says. The staff nurse told my investigator that she remembered the man who died. He was an older man who walked with a limp and had laughed during the assessment.
9. On the first page of the form, staff record personal details and information on the prisoner's status. The staff nurse told my investigator that she obtains some of the basic information from the prisoner's personal summary sheet. The staff nurse did not complete the box marked 'Current Charge' as she did not have the man's personal summary sheet in front of her at the time. She said that she had seen it briefly before she spoke to the man but she had not noted that he had been charged with murder. She also said that she does not always ask prisoners about their offence as sometimes they do not give her the correct information. The man told her he was of no fixed abode and added that he had previously been in prison in 2005. He then said that he was not registered with a General Practitioner.
10. The second page of the health screen form records a new prisoner's physical health and needs. At the very top of the page, above the heading 'physical health', an instruction states, "If charged with murder or manslaughter, refer for mental health assessment." As the staff nurse did not know that the man was on remand for murder, she did not refer him for a mental health assessment.
11. The staff nurse recorded that the man's right knee was swollen and that he had been prescribed a strong painkiller for this. She also noted on the form that he was allergic to penicillin, but she did not record this information on the continuous clinical record as required. When asked whether he used alcohol or drugs, the man replied no to both. The next section of the form covers the prisoner's mental health. The man said that he had never been treated for such problems, nor had he ever tried to harm himself. A further question is whether coming into prison is so difficult that the prisoner is considering harming himself. When the staff nurse asked this question, the man responded by laughing and saying, "Oh Miss, no. An old man like me?" The staff nurse told my investigator that this reply and the man's manner throughout the assessment led her to have no concerns about his mental health. She ended the interview by referring him to the doctor about his knee.
12. Reception procedures at Brixton are kept as brief as possible so that new prisoners are only held in the reception area for a short time. The remainder of the induction process is carried out on the wing. After the health assessment, the

man went to the induction unit. At the time, this unit was located on G wing, along with the detoxification unit. It is now on C wing. In the induction unit, prisoners are interviewed by the first night officer. The officer completes the first night in custody questionnaire and cell sharing risk assessment (CSRA) to decide whether the prisoner should be put in a shared cell. He also provides information about the prison and again assesses how well the man is coping with custody.

13. The reception officer asked the man about the charge against him and was told it was murder. He told my investigator that he recalled the man as a mature man who was very calm and very matter of fact about the charge. The reception officer usually completes the first night form first as he has found that this 'breaks the ice' and helps with the later risk assessment. When prisoners are asked if their family know they are in prison, the usual answer is "no". The man must have given this reply as the word 'no' is ringed. Although the reception officer cannot remember whether the man wished for his family to be contacted, he is likely to have asked as it is noted on the form. When a prisoner wants to contact his family, the reception officer explains that it is up to them to do so using the Pinphone system. He asks if they know how to use the system and briefly explains the process to those who do not.
14. The reception officer then completed the CSRA. This form asks whether a prisoner has concerns about sharing a cell and the man who died said he had. He was assessed as medium risk rather than high risk. The reception officer also noted that the man was a non smoker. He told my investigator that he had no concerns about the man, otherwise he would have opened an ACCT document. (The ACCT document describes the problems facing a prisoner at risk of harming himself and implements a plan to give him the support he needs to help him through a period of crisis.)
15. The man who died was then seen by a doctor. The doctor noted that the man was suffering from dyspepsia and that he was walking with a limp. The man told the doctor that he had injured his thigh three weeks previously. He added that he was waiting for a right patella (knee-cap) replacement. The doctor prescribed medication for the dyspepsia and referred the man for an x-ray of his knee. There is no record of the man being prescribed pain killers or any evidence that he had such medication in his possession.
16. During the evening, prisoners are given a hot meal and are free to move about the wing. They can also have a shower, use the telephone and talk to a Listener if they wish. (Listeners are prisoners who have been trained by the Samaritans to offer confidential emotional support to fellow prisoners in distress. There are always Listeners on duty in the induction unit at Brixton.)
17. The following morning (23 February), the induction process continued. Prisoners were given information about prison procedures and the help offered by prison staff and outside agencies. On that day, staff at Brixton identified the man who died as a potential category A prisoner and moved him to G3-21, a single cell on G wing. While the decision was being made, the man was subject to certain category A measures, including regular checks. It appears that the man spent the remainder of his time in Brixton on G3 landing which is on the first floor.

18. On Monday 26 February, the senior officer (SO) on G wing was informed that the man's category A status had been confirmed. The senior officer went to the man's cell between 4.00pm and 5.00pm to pass on this information. He told my investigator that it did not seem to come as a shock to the man who said that he had been charged with a murder committed two weeks earlier. The man sat on the edge of the bed, very relaxed and asked questions calmly. He made eye contact with the senior officer and his body language was positive. The senior officer is an ACCT assessor and case manager. Accordingly, he has a great deal of experience in looking for signs that a prisoner is not coping. He said that the man appeared fine and, in his opinion, the news probably did not come as a surprise. The senior officer told the man that he would be transferred to HMP Belmarsh, which holds category A prisoners, as soon as possible.
19. On 27 February, a prison officer was the landing officer for G3. His duties included carrying out hourly checks on the man and signing the record to show that he had done so. The prison officer explained to my investigator that he checked the man once each hour between 7.00am and 10.00am but not necessarily at regular intervals. He signed the man's category A booklet to this effect. After 10.00am, there are no further entries in the booklet. The prison officer said that he might have checked on the man between 10.00am to 12.00 noon and not had time to make the entries in the booklet, but he could not be sure.
20. The prison officer told my investigator that he looked through the observation hatch in the door to check that the man was in his cell but did not speak to him. He could not recall what the man was doing at the times he looked, but he was clear that the man gave him no cause for concern during the morning.
21. At lunchtime, a second officer assisted in unlocking the prisoners on the landing and supervising them whilst they collected their lunch from the servery on the ground floor. When the landing officer unlocked the man's door he glanced in, realised something was wrong and entered the cell. He saw the man standing under the window, facing the door and looking down slightly. As he moved closer, he realised that the man was hanging from the window bars. A bed sheet had been used as a ligature. The officer immediately went to the door and called a 'Code 1' to alert the other staff that there was a medical emergency.
22. The second officer ran along the landing and called Code 1 over his radio. He also told the prisoners on the landing to ring the cell bell to alert other staff to the emergency. He then went into the cell and supported the man's weight whilst the landing officer cut the bed sheet from the window bars. They laid the man on the floor and removed the ligature from his neck. The landing officer then raised the bed onto its end to make more room in the cell.
23. Another officer and senior officer arrived at the cell and began to administer first aid. The officer tried to put an airway into the man's mouth to start cardiopulmonary resuscitation (CPR). However, he could not do so because the man's jaw was shut tight as rigor mortis appeared to have set in. The senior

officer then tried but he too was unsuccessful. The staff then began CPR and continued until healthcare staff arrived.

24. The duty staff nurse heard the alarm bell and went to the man's cell. As the officers continued CPR, she examined the man. She could not find a pulse and noted that he was cold and his legs and arms were quite stiff. She then took over the chest compressions. A senior healthcare officer arrived, as did other staff with oxygen, the resuscitation kit and a defibrillator. (A defibrillator is a machine that treats victims of sudden cardiac arrest by delivering a shock to the heart.) The senior healthcare officer attached the defibrillator to the man. It showed no heart activity. He tried to insert an oropharyngeal tube into the man's mouth and, when he was unable to do so, he used a bag-valve mask to try to get oxygen into him. He told my investigator that, although he did all this, his professional opinion was that the man was already dead. At approximately 12.15pm, he and the other healthcare staff agreed that nothing more could be done. At that point, the paramedics arrived and attached their equipment to the man. The reading on the machine confirmed that he had died so the staff ended CPR at 12.17pm. At 2.33pm, one of the prison doctors came to the cell and, after examining the man, certified his death.
25. At 12.40pm, staff spoke to the prisoners in the neighbouring cells and informed them of the man's death. One of the men in cell 3-20 said that he had heard kicking on the pipes at approximately 11.00am that morning.
26. The staff who found the man and those who attempted to resuscitate him were then taken to the rest area in the gymnasium where they wrote out their statements. Members of the care team were available for staff who needed to speak to someone. Afterwards, the staff attended a hot debrief in the prison chapel. The healthcare staff attended an additional debrief at which the resuscitation attempt was the main focus of discussion.
27. Meanwhile, prison managers began trying to trace the man's next-of-kin. He had given no family details when he arrived at Brixton. The police were contacted, but the address they provided was out of date. Staff at Brixton were still making enquiries two days later when tabloid newspaper reported the man's death. His son contacted staff at Brixton who confirmed his identity and then gave the family the assistance they needed.
28. After the man's death, several letters were found in his cell addressed to the police, his lawyer and the family of his ex-partner. In the letter to the police, he had written, "...we loved each other so much ... I cannot live out (sic)..." followed by his former partner's name. The letter had been written at some point on the morning of Tuesday 27 February.

ISSUES

29. On completing the health screen, the reception nurse did not refer the man for a mental health assessment as she should have done. She explained that, because of time pressures, she had not made a note of the charge against him when she looked at his documents in reception. This meant that she was unaware that he had been charged with murder and so did not refer him to the mental health in-reach team.
30. However, during the assessment, the man said and did nothing to cause the nurse any concern. She recalled him actually laughing when she asked if he felt like self-harming. Had she had any concerns, she is quite clear that she would have referred him to the mental health team or opened an ACCT. The man was later interviewed by an officer in the induction unit. He had no concerns either.

The Head of Healthcare should remind staff of the importance of obtaining all the information necessary to complete the first reception health screen fully and to transfer important information into the continuous clinical record.

31. As a category A prisoner, the man should have been checked once an hour. On 27 February, the records show no checks after 10.00am. The landing officer that morning signed three times to show that he had completed the checks between 7.00am and 10.00am. He told my investigator that on the morning of 27 February he had been very busy looking after the prisoners on the 'threes' landing. Several were subject to ACCT monitoring and two of them needed a lot of attention. He said that he might have checked the man after 10.00am and simply not had the time to record it.

The Governor should remind all staff of the absolute necessity of carrying out and signing to confirm all required checks on category A prisoners.

32. Notes that were found in the man's cell after his death indicate his intention to take his own life. In one, he appeared to refer to a previous unsuccessful attempt involving pills, although there is no indication of when this took place. There is no evidence from his prison records that it happened whilst he was in prison as such action would have led to the involvement of healthcare staff and an ACCT document being opened. Therefore, it may well have occurred before his arrest.
33. The failure to ensure a mental health referral and the possible failure to carry out category A checks are matters that the Governor will need to address. However, even if they had been completed, I suspect that the man was a sufficiently experienced prisoner to have worked round the procedures. The letters in his cell expressing regret for his former partner's death and his unwillingness to outlive him would point to his resolve to end his life.
34. After the man's death, prison managers liaised closely with the police to try to obtain the contact details for his next-of-kin. However, on 1 March, his son contacted the prison after seeing a report of his father's death in a newspaper. It must have been a great shock to the family, particularly as the tone of the report

was sensationalist. However, I am satisfied that staff at Brixton did all they could to try to trace the family. When the man's son contacted the prison, the Governor and his staff offered a good level of support and care.

RECOMMENDATIONS

The Head of Healthcare should remind staff of the importance of obtaining all the information necessary to complete the first reception health screen fully and to transfer important information into the continuous clinical record.

The Governor should remind all staff of the absolute necessity of carrying out and signing to confirm all required checks on category A prisoners.