Investigation into the death of a man at HMYOI Brinsford in March 2007

Report by the Prisons and Probation Ombudsman for England and Wales

April 2008

This is a report of an investigation into the death of a man. The man was just 19 years old when he took his own life in his cell at HMYOI Brinsford. He had been in custody there for just two weeks.

I would like to offer my sincere condolences to the man's family on their tragic loss.

I must also apologise for the delay in issuing this report. The Primary Care Trust who had responsibility for completing the clinical review rightly wanted to produce a thorough and comprehensive document. Unfortunately, this took much longer than expected to complete.

The investigation was undertaken by my two of my colleagues. We would like to thank the Governor of Brinsford and his staff for their participation and assistance. South Staffordshire Primary Care Trust undertook a review of the man's clinical care. I must also thank them for the review.

In tragic circumstances, I have been impressed by the compassion and professionalism demonstrated by the officers who discovered the man in his cell and attempted to resuscitate him. I am also impressed by the care and dedication displayed by Senior Officer in charge of the prison wing on which the man died, and by the Safer Custody team who work hard to try to prevent tragedies of this nature. However, I must also record that valuable information regarding the man's mental state was neither noticed nor acted upon by Brinsford. If it had been, I am sure he would have been monitored more closely and a more urgent referral made for a mental health assessment. It is also a concern that the man did not receive the medication that the prison's doctor said he had prescribed for him. These issues are considered in more detail in this report and in the clinical review.

I make a total of 12 recommendations.

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

CONTENTS

Summary	4
The Investigation Process	5
HMYOI Brinsford	7
Key Findings	9
Issues	19
Recommendations	23

SUMMARY

The man was discovered in his cell at HMYOI Brinsford early in the evening in March 2007 with a ligature tied around his neck. He had used a cord from a stereo, which he had borrowed from another prisoner that afternoon. Despite the efforts of staff, he could not be revived. He was just 19 years old when he died.

The man lived with his partner and was a father to three young children. Whilst he was at Brinsford, he remained in touch with his partner and other members of his family through regular telephone calls and letters. He also received visits, but he experienced problems with visiting orders for his mother which he brought to the attention of wing staff.

The man had been in custody previously. He arrived at Brinsford in March 2007 after being remanded into custody by the Crown Court for a number of relatively minor offences. He was unable to be bailed, as he had previously received a suspended sentence which was revoked when he allegedly committed the new offences.

Throughout his time at Brinsford, staff were concerned about the man's mental health, and an ACCT document (used to monitor prisoners at risk of suicide or self harm) remained open from 12 March until the day he died. The staff involved in opening and reviewing his ACCT took care to ensure they interacted with him and checked on him regularly. They made him aware of the support available, and one Senior Officer in particular spent time with the man to help him sort out some problems.

Staff in healthcare also spent time with the man but, although they too were concerned about his mental health, they did not raise an urgent mental health referral, instead making a routine one. The man was still on the waiting list when he died. Had any member of the healthcare been aware of a probation report which said that the man had tried to take his life on two previous occasions, I believe they would surely have taken a different and more urgent approach.

The staff who found the man tried valiantly to resuscitate him. He was pronounced dead by the prison doctor at 8.29pm.

THE INVESTIGATION PROCESS

1. I appointed two investigators to conduct the investigation on my behalf. Notices were issued to both prisoners and staff, inviting anyone who might have information on the man's death to make themselves known to the enquiry. However, no additional witnesses came forward.

2. My investigators were given access to all the man's prison records, including his medical records and police statements. They were also given copies of personal letters written to the man from his partner, along with transcripts of telephone conversations between them and between the man and other members of his family.

3. My investigator visited Brinsford in March 2007 to open the investigation and visit the cell where the man died. All the prison documents were forwarded to her within two weeks of her visit.

4. My investigators visited Brinsford on 24 and 25 May to carry out interviews. Due to staff sickness, they were not able to interview everyone they wanted, so returned to the prison on 27 June to carry out the remaining interviews.

5. My investigators used Brinsford's own tape recording machine to record interviews with staff, but this broke down on a number of occasions. This meant that handwritten notes needed to be taken. However, these were forwarded to staff for agreement in the usual way. Notes of the interviews with prisoners were also taken by hand (which is usual practice) and forwarded for their agreement as a true and accurate record.

6. A number of staff remained on sick leave throughout this investigation. However, I believe that police statements taken on the night the man died and shortly afterwards have provided the investigators with sufficient information.

7. One of my Family Liaison Officers contacted the man's partner and his father's partner by telephone. The Family Liaison Officer explained the role of the Prisons and Probation Ombudsman and asked whether there were concerns or questions they would like my investigators to consider.

8. The family raised several issues. They were concerned at the length of time it had taken for them to be informed of the man's death. (There was a delay of approximately six hours before the Prison Governor and his Family Liaison Officer arrived at the home of the man's mother.) They asked that my investigators consider how the ACCT process was managed. They also told my Family Liaison Officer that they had not been informed that the prison would contribute to the cost of the funeral until after they had already applied for financial assistance from the Department for Work and Pensions.

9. The family also believed that the man should not have been allowed a stereo in his cell as he had not earned this through the Incentives and Earned Privilege Scheme. They believed that staff should have been alerted to the fact that he had a stereo as he was playing loud music. The family also

questioned whether the man had been on an ACCT document at the time of his death. They were also concerned that he was being bullied when he first went to Brinsford and that some prisoners had been trying to take a watch from him. The man's partner asked why he had not been allowed to make a telephone call around 4.30pm on the day he died.

10. Another question was whether the man saw a doctor whilst at Brinsford and whether he was prescribed medication for his depression. Finally, when the family were given the man's possessions, they included a sheet of paper which was headed a self assessment check list. One of the questions on the checklist asked "How do you feel today" and the man had ticked "Very Low". The family believe the man completed the checklist the day before he died and want to know whether staff had seen it. My investigators asked prison staff about this and were told that the checklist was for the individual's personal use and would not have been seen by anyone else.

11. A clinical review of the man's health care whilst in custody was undertaken by South Staffordshire Primary Care Trust. As part of this review the prison's doctor and Charge Nurse were interviewed. (The Charge Nurse was one of the staff members who remained on sick leave throughout this investigation.) The clinical review team held an initial meeting on 31 July to review information and evidence about the man's care. Further meetings were held on 24 October and 22 November 2007.

HMYOI BRINSFORD

12. HMP and YOI Brinsford is situated north of Wolverhampton in Staffordshire and shares a large site with HMP Featherstone. The prison was opened in 1991 and cares for both juveniles (those aged 15-17 years) and young offenders (18-21 years).

Induction wing

13. The purpose of the induction wing is to house new prisoners before they are located on to a main wing, to provide them with information about the prison, and let them know what help is available. It is also where staff can identify prisoners who are vulnerable or at risk, and provide them with advice or take appropriate action, for example opening an ACCT document.

Assessment, Care in Custody and Teamwork (ACCT)

14. ACCT requires any member of staff who identifies concerns about a prisoner at risk of suicide or self harm to take action and to record those actions. The ACCT document should be available to all staff where the prisoner is located, including workshops and visits. Within 24 hours of an ACCT being opened, the prisoner is seen by an assessor and has a case meeting review. ACCT reviews are held at appropriate intervals and are attended by the prisoner and a case manager, together with other members of staff.

Healthcare

15. Brinsford's healthcare centre is located on the ground floor of a two-storey building shared with the induction, throughcare, support unit (ITSU). It has a 24 hour in-patient healthcare facility. Doctor cover is available five days a week, with an out-of-hours service commissioned by the Primary Care Trust. A mental health in-reach team works closely with healthcare staff.

Listeners

16. A number of prisoners at each prison are trained and supported by the Samaritans to be Listeners and to offer peer support. Other prisoners can speak to Listeners in confidence about any issues that affect them. Listeners are bound by confidentiality rules, like the Samaritans, and are unable to disclose any details about conversations they have had (unless it is a matter which threatens the security of the prison).

Anti-bullying Strategy

17. Brinsford has a specific anti-bullying manager, albeit with other duties. An anti-bullying protocol called BRAVES (Brinsford's Reducing Aggression and Violence Effectively Strategy) has been established and meetings are held monthly. At these meetings, staff review incidents of bullying, consider causes of bullying and analyse statistics and trends. All Senior Officers are

trained to be aware of signs of bullying, and to carry out investigations which they report back on at the meetings.

Prison Service Orders (PSOs)

18. PSOs are issued to every prison and detail the mandatory action to be taken regarding specific issues.

Offender Assessment System (OASys) Reports

19. OASys reports are assessments completed by the Probation Service in advance or after a court appearance. Each report provides information regarding the offence, and personal details (including accommodation, financial status, education, relationships and lifestyle), and produces a risk of harm summary. In the case of man who is the subject of this report, the OASys assessment included that he was at risk of suicide as he had taken an overdose a few weeks beforehand. The man also recounted to the probation officer how he had taken a car with the intent of driving it into a wall in an attempt to take his own life.

Incentives and earned privileges scheme (IEP)

20. The Prison Service introduced the IEP scheme in 1996 to encourage and reward good behaviour. There are three levels: basic, standard and enhanced. Incentives include access to in-cell television, more private cash to spend, wearing own clothes, more time out of cell and community visits. Each prison sets its own criteria for prisoners to obtain each level.

Independent Monitoring Board (IMB) Report

21. The local Independent Monitoring Board's report for 2005-2006 acknowledged that Brinsford held vulnerable prisoners and that the prevention of self harm and suicide was a significant challenge for everyone. The report referred to the successful introduction of the ACCT approach and was impressed at the number of staff who had received ACCT training. The Suicide Prevention Strategy had been revised and used as an example of good practice for other prisons. The Board reported that the Suicide Prevention Team met on a monthly basis and was well attended by both internal and external agencies. A cross-section of ACCT plans were reviewed for quality and accuracy each month. The IMB also noted that Brinsford had forged a constructive relationship with the Samaritans (something which also impressed my investigators) and that the Listener scheme had been re-launched. The IMB commended the small team of staff who contributed to this area of work.

Her Majesty's Chief Inspector of Prisons Report

22. The last inspection of Brinsford by HM Chief Inspector of Prisons, Ms Anne Owers, was in 2007. In her subsequent report, Ms Owers said Brinsford was struggling to provide appropriate levels of safety and decency.

KEY FINDINGS

23. The man arrived at HMYOI Brinsford in March 2007 from the Crown Court. This followed his conviction at the Magistrates' Court in January 2007 for several offences. It was the man's second time in prison, having previously served a sentence at Ashfield YOI.

First reception

24. The man attended a first reception health screen on 9 March, where he informed the healthcare assistant, that he had been seen by a psychiatrist seven months previously for stress. The man said he had been prescribed an antidepressant (Fluoxetine) and sleeping tablets (Diazepam) to relieve his symptoms. He told the healthcare assistant that he had stopped taking the medication approximately three months previously, as he had started to feel better.

25. On page eight of the first reception health screen document, the healthcare assistant indicated that the man should be referred to the doctor. In her interview for this investigation, the healthcare assistant recalled that the man had appeared quite tearful and upset and was worried about being away from his family. The healthcare assistant explained to the man the help and support that would be available to him at Brinsford, including the purpose of an ACCT document. The man told the healthcare assistant that he did not feel suicidal and did not need to be on an ACCT, but if he needed any help he would speak to someone. He was then located onto the induction unit.

Healthcare involvement

26. The man was seen in healthcare, following the healthcare assistant's referral, on 10 March at 7.20pm by a Registered General Nurse (RGN). The nurse noted in the Inmate Medical Record (IMR) that the man seemed very depressed and tearful and that he was missing his family and children. The man told the nurse that he felt he needed to resume taking his anti-depressants and sleeping tablets, and the nurse made a written referral in the IMR for him to be seen by the prison doctor. The nurse also gave the man some herbal tablets to help him settle that night.

27. There is an entry in the IMR the next day by the prison's doctor (who was the on call doctor). The entry is quite difficult to read but, with clarification from the doctor at interview, I understand it says that the man had been on "anti-depressants seven months ago, that he was not sleeping – on fluoxetine as of today". (The clinical review has said that urgent attention should be paid to improving the standard of legibility. I agree.) When the doctor was interviewed by the clinical reviewers on 17 September, he said that this entry was in fact a prescription that he had made out for the man. It is unclear from the entry that this was the doctor's intention as it was recorded in the Significant Events and Health Issues page of the IMR. The man did not receive this medication.

28. The man was seen again by the healthcare assistant on 12 March. He passed her as he was being escorted through healthcare and asked to have a word. The healthcare assistant recalled that they went to the staff room to talk. The man told her that he was having trouble coping and that he wanted to speak to his partner. The healthcare assistant arranged some credit to be put on his Pinphone account so he could speak to her. The man also told the healthcare assistant that he was having thoughts of harming himself. The healthcare assistant immediately opened an ACCT document and referred the man to be seen by the Charge Nurse at Brinsford. The healthcare assistant recorded her account of this conversation in the IMR.

29. The Charge Nurse saw the man the next day and made an entry in the IMR. He noted that the man was low in mood and very stressed. The man also told the Charge Nurse about his previous medication and agreed to forward the name of the psychiatrist he had seen. (In fact, he did not return with this information.) However, in the ACCT document it is noted that he was a patient of a psychiatrist in the community. No steps were taken to find out further information from the man's community doctor. Neither the ACCT document, nor the OASys report, was ever forwarded to anybody in healthcare. Brinsford have subsequently said that the OASys report would not have been accessed as the man was subject to judicial review. In normal circumstances the prison does not work with OASys on any offender who is not sentenced.

30. The Charge Nurse said that the man should be referred to the Staff Nurse for a full mental health assessment. The Charge Nurse noted that an ACCT document had been opened for the man, but that he had denied any intention of self harm or suicidal thoughts. At no point, however, were any members of healthcare involved in reviewing his ACCT plan. The Charge Nurse made a further entry in the IMR on that day. It says he called into the induction wing to see the man, but he was having a visit at the time.

31. The Charge Nurse's impression was of a man who was having some difficulty adapting to prison life. Although the man said he had no major concerns, the nurse completed a routine referral form for a mental health assessment by the Staff Nurse. This referral would normally take between two and five weeks and the Charge Nurse did not feel an urgent referral (which would take no more than two weeks) was necessary. The Charge Nurse said at interview there was nothing to suggest the man had any predominant mental health issues. Had he been aware or seen the OASys document he may have made an urgent referral.

32. There were no further entries in the IMR until a retrospective entry was made by another nurse after the man's death. There is no evidence to suggest that the man was ever assessed by the Staff Nurse.

ACCT plan and ongoing record of events

33. The ACCT document was opened on the man by the Healthcare Assistant on 12 March. The Temporary Senior Officer (T/SO) who was the unit manager on

the Induction wing was responsible for discussing the man's ACCT plan with him. On page three of the ACCT form, the healthcare assistant had highlighted the concerns she had about the man. The healthcare assistant noted that the man had been thinking of harming himself since being in custody and was very low in mood. It was noted that he should be seen by a mental health nurse due to his previous condition and medication.

34. The T/SO devised an immediate action plan with the man. The plan noted that he would prefer to be located in a shared cell. The T/SO considered moving the man to the vulnerable prisoners unit, but thought it best to give him the opportunity to settle on normal location rather than be located on a unit with prisoners who were segregated because of the nature of their offences. The T/SO also noted that the man should have three recorded conversations daily with staff and three recorded observations throughout the night. There were no set times for the interactions to avoid the man being able to predict when they would take place. The man was also given access to the telephone to speak to his partner and father. The T/SO explained the work of the Samaritans and the support that was available to the man at Brinsford. The T/SO noted an immediate intervention was that the man should be seen in healthcare for an assessment as he had stopped taking his antidepressants three months earlier.

35. The T/SO then carried out the mandatory tasks explained on page four of the ACCT document. She organised the man's case review, referred him to healthcare for assessment and briefed staff. She also recorded in the unit observation book the requirements for the conversations and observations he was to have. Finally the T/SO logged the ACCT document. Prison staff noted on 12 March in the on-going record part of the ACCT document (as part of the interactions and observations of the man) that he said that he was feeling fine and seemed upbeat.

36. An officer carried out an ACCT assessment interview with the man the following day (13 March). The man talked about what he believed his problems were. These concerned missing his family and the fact he had stopped taking his antidepressants. He said he had no thoughts of self harm, but contradicted this by saying he had had thought of hanging himself. However, he said he had not acted upon these thoughts because of his children and that they and his partner were his reason for living. The officer noted that the man's immediate plan was to look at ways to cope with boredom (such as visiting the gym, education and association), to ensure he received visits and letters, and to be assessed in healthcare with a view to reviewing his medication.

37. The T/SO also saw the man on 13 March, about 15 minutes after his ACCT assessment with the officer. The man told her that he felt okay, but had had thoughts of hanging himself the previous two days. He agreed that he was aware of the support available to him. He said he felt nervous about his transfer out of the induction unit and onto a wing. It was agreed that the man would stay on the Unit for another night, although this was also due in part to the lack of spaces on the wings.

38. The T/SO also completed a caremap on page 13 of the ACCT document. Two issues were noted for action. The first was that the man should be assessed in healthcare and be referred for a mental health assessment. The second was to contact his solicitor with a view to applying for bail. Both actions were completed later that day. The solicitor told the officer who completed the ACCT assessment that the man would not be eligible for bail, but it is unclear whether she passed this information onto him. The assessment of the man in the on-going record for the rest of the day was that he was interacting well with staff and seemed happy in a shared cell. He appeared cheerful when he returned from a visit and, when asked, said he was fine.

39. The next day (14 March) the man was transferred from the induction unit to the first night unit. As part of the ACCT process, the T/SO completed a review on page 14 of the document. At this review, the T/SO reviewed the man's level of risk as low. The T/SO also recorded that the man had thought of harming himself and had reservations about locating onto a wing. The T/SO asked that the man's progress and transition onto the wing should be monitored and warned that he might be a target for bullies because of his stammer. (This is not something that the man ever appeared to complain about, and does not seem in practice to have been an issue.)

40. In the on-going record for 14 March, a member of staff noted that the man was given a phone call to his solicitor who told him he would not be able to have bail. The note says that the man, "has accepted this with problem". (I assume this should have read without problem.) It was also noted that at 12.20pm the man chatted with staff about a transfer. He said he had no thoughts of self harm and had appeared chatty and upbeat. However, by 4.20pm that afternoon the man had told staff he was feeling low and wanted to see someone in healthcare. He was told he could do so the next morning, although there is no entry in the on-going record to suggest that this happened.

41. Later that evening, another member of staff spoke to the man. Although the entry is not annotated clearly (very few members of staff wrote their names rather than simply initialling their entries), it would appear that the staff member was a SO. The entry says that the SO had allayed some of the man's fears that he would come to harm if allowed to mix with other prisoners. The man said that his confidence had received a massive boost and they had agreed to sort out his canteen (purchases from the prison shop) and phone call issues the next morning. There is no earlier entry to explain what these issues were, but the man had got into debt through borrowing tobacco and it was likely that he was using his canteen to repay the debt.

42. It was noted on 15 March that the man said he had no problems and seemed content. It was also recorded that his canteen problems had been sorted out and his phone call had "been done". On 16 March, the man told staff he had no problems and seemed relaxed and settled.

43. On 17 March, the SO who had spoken with the man on 14 March made an entry in the on-going record section of the ACCT document. He noted that the man's mother had telephoned the prison and was concerned that her son's mood seemed very low. The SO spoke to the man who told him that he had been verbally intimidated (he gave no further details). He also discussed how he had become in debt to another prisoner through borrowing tobacco. The man commented on his Ben Sherman watch, which he seemed to be concerned about, although he denied that anybody had asked him for it. The SO said he would investigate the matter and speak to the man again the next day. (The SO would investigate the issues and also report back to the anti-bullying meeting as part of the BRAVES protocol.) An entry later that evening said that the man seemed better after his conversation with the SO and would be alright overnight.

44. The man's second ACCT case review was held the next day (18 March). He had been transferred from E1 wing onto G1 (although it is not clear from prison records why he was moved) and appeared much happier. The SO wrote in the on-going record of the ACCT document that the issue with the tobacco debt had been resolved. He noted that the man had been upset about it. They also spoke about the man's watch and the SO advised him to store it away rather than keep it in his possession. The man said he planned to do this and told his family that he had done so. The man's Prisoner's Property Record does not show that he put the watch into store, although an undated annotation on the record says "Ben Sherman Watch 01564170 Not on card". This may suggest that the watch was in fact stored away.

45. The man also told the SO that he had no thoughts of self harm at that moment. The SO encouraged him to telephone his partner and mother at the earliest opportunity. The SO noted that the man had seemed a little tearful after speaking to his partner, but had said he was okay. The SO thought that the man should remain on the ACCT plan (the next case review was due on 25 March).

46. The man continued to be monitored on the ACCT. On 19 March, he said he had no thoughts of self harm and was okay. The next day, he told an officer he felt down and was given a phone call. On 21 March, he interacted well with peers and did not speak about self-harming.

47. There was nothing else recorded of note until 22 March at 12.15pm when the SO made a further entry in the on-going record. He said that the man had appeared to be very tearful and said he did not think he could cope in prison. They discussed the fact that the man could not be transferred until he had been sentenced and how much he was missing his family. The SO recorded that the man appeared more settled after their conversation and he had advised him to consider speaking to the landing Listeners. The man replied that he was not interested in doing so at that time, although he did actually speak to one of the Listeners later that day. Although the Listener was unable to disclose the exact nature of their conversation, he said at interview that the man was crying when he first spoke to him but seemed better by the end of the conversation. The Listener said he was shocked when he heard that the

man had taken his own life. He had seemed okay at lock up that day and thought their conversation had helped him.

Events of 23 March 2007

48. There is an entry in the on-going record in the ACCT form which says that the man was unlocked at 7.45am on 23 March 2007 and had seemed to be in a good mood. When asked by an officer how he felt, he replied that he felt alright and he was given a phone call. Phone records show that he made 16 telephone calls that day. He made a call at 7.45am which lasted three minutes and 26 seconds. He made another call to the same number at 10.20am, but phone records show there was no reply. The man made a further six calls between 10.20am and 11.14am, but only the final call appeared to connect. It lasted 31 seconds. The man made eight calls to his partner's mobile phone between 10.21am and 11.13am. Only one call to this number at 10.46am appeared to connect. It lasted for 23 seconds. Phone records show that on five of these calls the person receiving the calls hung up and the caller hung up three times. The man's partner said that she kept losing her mobile phone connection, as she was in a poor area for reception. A fellow prisoner at Brinsford said at interview that he had heard a rumour that the man had an argument with his family on 23 March. He had not witnessed this himself.

49. The man was spoken to by a prison officer at 11.05am as part of the three daily interventions written into the ACCT document. An entry was made in the ACCT that he seemed alright and there were no problems or concerns. Another officer spoke to the man at 1.00pm when he stated he was fine and seemed content. At 2.30pm, the man spoke to another officer about a visiting order (VO) for his mother. It seemed that the man had missed the opportunity of a visiting order when he moved wings, and had effectively missed a week's worth of visits. His mother had telephoned the prison to try to clarify the situation. The officer wrote that the VO would be issued the next day and the man seemed satisfied. That is the last entry made in the ACCT document.

50. From the interview with the Senior Officer in charge of the wing it is possible to account for the rest of the man's day. The SO said that an officer had spoken to her as he was concerned that the man's cell-mate had gone to court and this meant that the man would be alone. The officer had arranged for the man to spend time out of his cell cleaning the landing, interacting with other landing cleaners (who were also trained Listeners) and using the telephone. The man's last call was made at 11.14am and lasted 31 seconds.

51. The officer wanted to check with the SO in charge of the wing that she was content for the man to spend the lunchtime alone in his cell. The officer had spoken to the man and asked him how he felt and whether he was going to do anything silly. The man replied, "No, I wouldn't do that". Based on this information, the SO confirmed that the man could have lunch on his own. After lunch, the man had been seen back out on the landing and again he had used the telephone (although there is no printout of any calls being made on

the phone records). Some of the prisoners whom the man talked to were Listeners, although he did not speak to them in that capacity.

52. Another prisoner told the investigation that he heard the man call out from his cell for an officer at about 4.30pm. The prisoner went to the man's cell and said there were no officers on the wing. The man said he wanted to make a telephone call and the other prisoner told him he would have to wait until that evening. The prisoner said that the man had seemed happy with that. (It is probable that the time the other prisoner recalls is incorrect as the man was unlocked until 4.50pm and the other prisoner was not unlocked for the gym until 5.30pm.)

53. At 4.45pm, the SO in charge of the wing had another conversation with the officer about whether the man should be in a cell on his own. His cell mate had not returned from court (in fact he did not return to Brinsford at all). As the man had seemed to be in quite a jovial mood, had responded positively to all the interactions with staff during the day, and had already spent the lunchtime alone in his cell, the SO agreed that the man could go back into his cell until tea time. The SO would then reconsider what to do after tea if his cell mate still had not returned from court. Before the man returned to his cell at 4.50pm, he asked the other prisoner if he could borrow a stereo from him as he had two in his cell. The other prisoner also lent him a CD. (Borrowing the possessions of another prisoner is commonplace but against Prison Rules. Any items found in a prisoner's cell during a cell search that do not appear on their property card should be removed. However, staff would not have known that the stereo in the man's cell was unauthorised until or unless they read his in possession property card and carried out a cell search.)

54. At approximately 5.30pm, the other prisoner and the Listener, who were located in the cell opposite the man, were unlocked early so they could go to the gym. The officers and the SO in charge then began to unlock the rest of the landings in their usual order to allow the prisoners out to collect their tea. G1 landing, where the man was located, was the last to be unlocked.

55. The SO came to the man's cell at about 6.30pm. She looked through the flap in the door before unlocking it and saw that he appeared to be hanging. The SO immediately entered the cell, followed by another officer. The SO told the investigation that the man was almost sitting on the floor, with his legs outstretched towards the door. He had tied an electrical cable from the stereo to the frame of the bunk bed and had attached the other end around his neck. The SO called out for someone to raise the alarm whilst she and the officer went to cut the man down.

56. The officer supported the man's body, while the SO cut the ligature using her anti-ligature fish knife (a specially designed knife carried by all front-line staff). In the meantime, another officer had taken the SO's radio to make a call for urgent medical assistance and request an ambulance. The first nurse to arrive at the scene recalled at interview that a call was made for a medical emergency over the radio. However, the location of the cell with the emergency was incorrect and she ran to the wrong location before being re-

directed to the man's landing. At interview, the nurse said her colleagues in healthcare had not been aware of the emergency as they had not heard the call. One colleague had not been issued with a pouch to hold the radio, and the other's radio battery was flat.

57. The SO in charge of the wing and the officer who had entered the cell with her placed the man on the floor and the SO checked for breathing and a pulse but found neither. The SO confirmed at interview that she held a current first aid qualification. Rigor mortis had not set in and the SO began attempts to resuscitate the man. She placed a mask over his mouth and she and the officer commenced cardio pulmonary respiration (CPR). The officer began working on chest compressions whilst the SO concentrated on mouth to mouth resuscitation. They worked at a ratio of two breaths to every 15 compressions. (The universal recommended ratio is two breaths to every 30 compressions, although a ratio of 2:15 is suggested by some authorities when two people are involved in the rescue attempt.) There were no defibrillators located on the wing, although there may have been one in healthcare. Access to a defibrillator might have been helpful, as it would have indicated to the SO whether the man had a shockable heart rhythm.

58. When the nurse arrived at the cell she volunteered to take over the mouth to mouth resuscitation from the SO who was visibly tiring. Three officers had arrived at the cell shortly after the SO and the first officer on the scene had entered the cell. One of those had used the SO's radio to request medical assistance, another relieved the first officer on the scene and took over administering chest compressions from him. The nurse, who had been suffering from a heavy cold and had run a distance of about a quarter of a mile to the man's cell, began to tire so the SO took over the mouth to mouth resuscitation again.

59. The third of the three officers to arrive at the cell heard over the radio that an ambulance was on its way so went to wait for it at the gate, ready to escort it through the prison. The first response team arrived within a few minutes. The paramedics relieved the officers and continued with the attempts at resuscitation. Another ambulance crew arrived about ten minutes later and brought equipment with them. They continued to work on the man for approximately another half an hour but were unable to revive him.

60. The prison's on call doctor arrived at the prison at 8.10pm where he was escorted to the man's cell. The doctor examined the man's body and confirmed there were no vital signs. He pronounced death at 8.29pm.

61. Whilst staff were trying to resuscitate the man, other prisoners began to make some noise as they had not been unlocked for tea and were not aware of what was going on. Staff told the prisoners that there was an emergency and the officer who had escorted the ambulance arranged for those who worked on the servery to be unlocked to plate up the meals for the others. Officers then delivered the meals to their cells. From interviews, it does not appear that staff specifically explained to prisoners what had happened to the man, or

checked whether they were alright when they did this, as they were unsure whether it would be appropriate.

62. Staff were asked to remain at the prison while the police took statements from them. The Coroner's Officer also arrived later that evening. At around 11.00pm, the Governor held a de-brief. At interview, staff spoke of being expected to arrive for the normal duty the next day - despite staying late that evening and the traumatic experience of the man's death.

63. The prison's Family Liaison Officer, a Principal Officer (PO), the Governor and the prison Chaplain left the prison at approximately 1.00am to visit the man's next of kin to break the news of his death. The PO had advised the Governor that this information should be given by them rather than the local police. Unfortunately, there was a considerable delay in leaving the prison as the PO was the designated person who had to assist the police and wait for the Coroner's Officer to arrive. With hindsight, it would have been sensible for another member of staff either to have attended to the police or to have visited the man's family.

64. The man had named his mother as his next of kin and it was agreed that the PO, the Governor and the Chaplain should visit her personally. They were met by local police at about 2.00am and escorted to the man's mother's home. They arrived there at 2.10am. After breaking the tragic news, they gave her information about the PO's role and about procedures and details of associations who deal with bereavement. An offer was made to pay for the man's funeral and to accompany his mother to visit her son in the Chapel of Rest. They also told the man's mother that she and other family members were welcome to visit Brinsford to lay flowers in the cell where the man died. The Governor agreed to put all this information in a letter. (He did so on 23 March, but the letter did not reiterate all the information including the offer to pay for the man's funeral.) The man's mother said she needed to go to tell the man's father what had happened and, at her request, the prison's representatives did not accompany her. They left her house at 2.30am.

65. A further critical incident de-brief was held a week or so later. Staff at interview commented on how well they had been supported by members of the Care Team but felt less supported generally by senior managers. In particular, my investigators were told that staff were asked to return to duty as soon as this de-brief finished, before refreshments were served and before staff had an opportunity for an informal talk about what had happened.

66. A post mortem was held on 28 March. This concluded that the man died as a result of hanging and that the marks on his neck were consistent with a ligature. There was no other evidence of external violence or of any pre-existing disease that would have contributed to his death. The cause of death was asphyxia by hanging.

67. The PO rang the man's mother on 2 April. He enquired whether the prison could help with the cost of the funeral. The man's mother said she was having problems with the cost and gave the PO the details of the funeral

directors. The PO rang the man's partner on 5 April. He asked whether she wanted to visit the prison and meet some of the prisoners who had known the man. The PO also explained that the Governor had agreed to pay for the man's funeral and that, as soon as they had paid the invoice, the funeral directors would reimburse any deposit the family had made. The man's partner said she would pass on this information to the man's mother. She said she would also consider visiting Brinsford after the funeral, but could not think about it then. The man's funeral was held on 10 April.

ISSUES

Clinical issues

68. The man told wing and healthcare staff involved that he had stopped taking his prescribed anti-depressants and sleeping tablets about three months before he arrived at Brinsford as he had begun to feel better. He asked for the prescription to be renewed. On 11 March 2007, he had an appointment with the prison doctor who recorded that he was to receive some medication. However, the doctor did not complete a prescription chart to alert healthcare staff to his intentions. The clinical review says that the completion of this documentation is the responsibility of the prescribing doctor. After making further enquiries, the clinical reviewers confirmed that no prescription was ever received in the dispensing pharmacy.

The Primary Care Trust should review the actions of the prison doctor. They should also ensure that prescriptions for any medication are completed on the correct documentation.

69. The clinical review also found that standards of record keeping were poor and inconsistent. The review says that urgent attention should be paid to improving the standards and legibility of the documents in the interests of both prisoners and professionals. My investigators found this also to be the case when non-healthcare staff annotated other documents such as the on-going record in the ACCT.

The PCT should ensure the standard of documentation is improved in prison records, for example the use of abbreviations, and all entries made in prison documentation should be signed with a legible and printed signature.

The Governor should consider ways of improving the standard of documentation in prison records.

70. The Charge Nurse made a mental health referral for the man, but he remained on the waiting list until the day he died. Another referral was also made by the T/SO Unit Manager. If either had been aware that the man had tried to take his own life on two previous occasions (from information in the OASys report) a more urgent referral would surely have been made. It can only be assumed that the report was kept with the man’s core record and filed away, despite the valuable information it contained. The clinical review found that there were no formal protocols in place for such referrals, nor any clear guidance on how to prioritise referrals and on the acceptable length of time to be on a waiting list for a referral.

The Governor should ensure that prisoner’s documentation is checked for incidents of previous self-harm and that this information is passed to the appropriate department.

71. There was no defibrillator on the wing where the man died. If staff had had access to, and been trained to use the machine, the SO would have been able to detect whether the man had a shockable heart rhythm before commencing CPR.

Staff should be trained to use, and have access to, defibrillators on the wings.

72. The clinical review concluded, after consideration of the records, their investigations and associated paperwork, that the man received a level of care equivalent to that received in the community, with the notable exception that he did not receive the anti-depressants that the prison doctor said he prescribed for him. The clinical review says that the Primary Care Trust must take action to address this matter.

A review of the Out of Hours service provider should be carried out to ensure that appropriate documentation is completed and that correct processes are in place for writing prescription charts. Also that entries made in the IMR meet national record keeping standards.

73. The clinical review makes a further recommendation concerning a service review of Brinsford's Primary Mental Health Service. This does not directly relate to the circumstances of the man's death and has been addressed separately to the Chief Executive of the Primary Care Trust as have three examples of good practice.

ACCT

74. The ACCT document was opened when staff first became concerned about the man. The documentation and reviews were carried out appropriately, as was the level and frequency of interactions and observations. However, some actions did not appear to be followed up, for example when the man requested to be seen by someone in healthcare on 14 March. It is also not clear whether the officer who carried out the ACCT review on 13 March told the man that he would not be eligible for bail (although he was told this himself after he had spoken to his solicitor). No healthcare staff were ever involved in the ACCT reviews. This would have provided some cohesion between the healthcare and the wing staff who were responsible for monitoring the man.

The Governor should ensure that actions noted in an ACCT document are followed up by staff.

The Governor and PCT should review the input of the healthcare team into ACCT reviews, in particular when a patient is awaiting a mental health assessment.

75. The actions taken by the officer and the SO on 23 March show that they were concerned about the man and carefully thought through their actions. The SO decided to allow the man to have lunch in his cell alone and the officer kept

him out on the wing to interact with staff and other prisoners, including those who were Listeners. As the man had seemed fine, the SO made a considered judgement that he could be locked up alone again at tea-time. As this had already been the case at lunch, and given that the man had seemed okay and had been interacting with staff and discussed a visiting order for his mother, it was not unreasonable for the SO to make this decision. It is to their credit that the SO and the officer thought through the decisions based on what they believed to be in the man's best interests. (I have been impressed generally by what I have learned of the SO's professionalism, and the Governor may wish to consider if this should be formally recognised in some way.)

Bullying

76. I have found no evidence to suggest that the man was bullied because of his stammer whilst he was at Brinsford. It is unclear whether he was ever asked for his watch by other prisoners and, although he mentioned that he had been verbally intimidated, he gave no further information. The man's family believe that he was having trouble with relationships with other prisoners but, aside from two issues about his watch and the debt he was in, he did not discuss this with staff. The SO who made an entry on to the man's ACCT on 14 March spent time talking to him about this and gave him advice which seemed to help. The debt issue also appeared to be resolved, again with help from the SO.

Prison radios

77. At interview, the first nurse on scene spoke of the difficulties healthcare staff had experienced with prison radios. On the evening that the man died, her healthcare colleagues were unaware of the emergency as they did not have radios. One person did not have a radio because there were no pouches available and the other's battery had gone flat. The nurse recounted another occasion when she worked a nightshift with no radio as the battery was flat as it was in the replacement she was given. I am pleased to learn that the Governor has already taken steps to rectify this matter.

All staff, including healthcare staff, should be issued with working radios and pouches. The Governor should remind staff of the importance of the correct use of codes and other information in emergency situations.

The man's self assessment checklist

78. The man's family raised as a matter of concern a checklist which was returned to them with his property. This document had not been forwarded to my investigators to consider as it was amongst his possessions and not amongst any prison documentation. On the checklist, the man had assessed himself as feeling very low and his family believe this was completed on the day before he died although this is not certain. If the form had been issued to the man and he was meant to return it to a member of staff, then clearly he did not do so. Unless the checklist had been shared with staff they could not

be expected to act upon it. However, it is clear to see from other prison records that the man's mood varied frequently and that staff were already monitoring him through the ACCT.

Informing the family

79. My investigators were concerned at the length of time taken to inform the man's mother of his death. Whilst there is always the need for liaison and co-ordination at the prison after a death, consideration of the needs of the bereaved family should be foremost in people's minds. If the PO who was the designated Family Liaison Officer was, as he said at interview, fully occupied with escorting and liaising with police and then awaiting the Coroner's Officer, arrangements should have been made for another member of staff to take over this role to allow the PO and the Governor to visit the family.

The prison should ensure that the family of the deceased is notified of the death at the earliest opportunity.

Support for staff

80. At interview, a number of staff voiced concern about the level of care they received after the man's death. Most spoke of being kept at the prison until late on the day he died, with an expectation that they report for their shift the next day. Brinsford have since said that the Duty Governor and the Care Team arrived on the unit very quickly and that staff were told if they had to stay late to speak to the police they would not need to return first thing in the next morning. One officer spoke of the arrangements for the critical de-brief, where staff were told to return to work immediately after it ended without time for an informal chat and refreshments. I am not sure if this was coincidence, but I note that a number of staff who were involved in attending to the man's death then began an absence of long term sick leave.

All staff involved in a death in custody should be offered appropriate care and support by senior managers, as well as the Care Team, and time given for a thorough de-brief afterwards.

Support for prisoners

79. Staff seemed uncertain about the best way to inform prisoners about what had happened to the man. It seems likely that his death would have had an impact on some prisoners, especially those with whom the man spent time. Staff should have been briefed on how best to ensure they felt supported.

Prisoners who are affected by a death should be made aware of the support available to them, whether it be through the chaplaincy, wing staff, Listeners or Samaritans, and given the opportunity to talk.

RECOMMENDATIONS

To the Governor

1. To consider how the standard of documentation in prison records can be improved.

2. To ensure that prisoner's documentation is checked for incidents of previous self-harm and that this information is passed to the appropriate department.

3. To ensure that actions noted in an ACCT document are followed up by staff.

4. To ensure all staff, including healthcare staff, are issued with working radios and pouches. To remind staff of the importance of the correct use of codes and other information in emergency situations.

5. To ensure that the family of the deceased is notified of the death at the earliest opportunity.

6. To ensure all staff involved in a death in custody are offered appropriate care and support by senior managers, as well as the Care Team, and time is given for a thorough de-brief afterwards.

7. To ensure prisoners who are affected by a death are made aware of the support available to them, whether it be through the chaplaincy, wing staff, Listeners or Samaritans, and given the opportunity to talk.

To the Governor and the Primary Care Trust

8. Staff should be trained to use, and have access to, defibrillators on the wings.

9. To review the input of the healthcare team into ACCT reviews, in particular when a patient is awaiting a mental health assessment.

To the Primary Care Trust

10. The Primary Care Trust should review the actions of the prison doctor. They should also ensure that prescriptions for any medication are completed on the correct documentation.

11. The PCT should ensure the standard of documentation is improved in prison records, for example the use of abbreviations, and all entries made in prison documentation should be signed with a legible and printed signature.

12. A review of the Out of Hours service provider should be carried out to ensure that appropriate documentation is completed and that correct processes are in place for writing prescription charts. Also that entries made in the IMR meet national record keeping standards.