The circumstances surrounding the death of a man in HMYOI Brinsford, in February 2005

Report by the Prisons and Probation Ombudsman for England and Wales

June 2006

This is the report of an investigation into the circumstances surrounding the death of a man in February 2005. He was on remand at HMYOI Brinsford at the time of his death. He was only 19 years old. The cause of death was hanging.

The man was known to use a particular surname for most of his life, but when arrested for the offences for which he was remanded to Brinsford, he gave an alternative surname. This is his mother's family name and the name on his birth certificate. During the brief time he was in Brinsford before he died, he was known by the surname on his birth certificate.

Two of my investigators carried out the investigation on my behalf and one of my Family Liaison Officers (FLO) conducted the liaison with the man's family. A clinical review into his medical care and treatment was commissioned from a specialist in substance misuse.

I wish to extend my thanks to the staff at Brinsford for their co-operation during this investigation.

I very much regret the delay in completing this report and I know it has caused the man's mother some distress. As in a number of my other investigations, I have been unable to finish my work until the police have finished theirs. This is entirely proper, but I understand the added pain it can cause to bereaved relatives. I hope that a new protocol agreed between my office and the Association of Chief Police Officers may help to minimise the delays in the future.

Stephen Shaw
Prisons and Probation Ombudsman **June 2006**

Contents

Summary

The man was remanded to Brinsford on 27 January 2005. It was neither his first time in custody nor his first allocation to Brinsford. He was due to appear in court on 17 February and was not expecting to receive a custodial sentence. On reception, he was assessed by healthcare staff and went through the usual reception procedures. He was located on the induction unit (ITSU) and the following day he started a 14 day subutex detoxification programme.

On the morning of 12 February, the man saw a nurse because he had toothache. He was given a painkiller and returned to his cell, G2/19. Later that evening he attended association on G2 landing and was seen talking and laughing with several of the other prisoners. At approximately 7.30pm, the prisoners were locked up for the night and the man and his cellmate talked to the landing cleaners through their door.

Shortly before 9.05pm, an Operational Support Grade (OSG) responded to a cell bell from the man's cell. He said the man's cellmate was banging the door and calling for staff. The OSG subsequently unlocked the cell and entered. He said he found the man on the cell floor. Emergency assistance was summoned and attempts were made, both by staff, and later by paramedics, to resuscitate him. These were unsuccessful and the man was pronounced dead at 9.50pm.

The post mortem later determined the cause of death as cerebral anoxia due to hanging.

The man's cellmate has offered differing accounts of the circumstances in which he discovered the man. The post mortem found no evidence of defence wounds or other suspicious circumstances.

There is evidence from previous prison records, and from information provided by his family, that the man had attempted self harm and suicide before, and that he was bullied on a previous sentence in Brinsford. However, I have found no direct evidence that he intended to take his life on the night of 12 February. He appeared to be in good spirits on the day and was making plans to tackle his drug problem and to be a father to his two children.

There are conflicting accounts of the response to the man's death of the first two members of staff on the scene. Nonetheless, it was extremely distressing for the family, and unpleasant for the staff and prisoners on G2 landing, for the man's body to remain in the corridor outside his cell for some seven hours after he died pending the attendance of the undertakers. According to the Governor, who managed the prison's immediate response to the man's death – this was done on the instructions of the police.

I judge that the regime for young offenders at Brinsford is poor, with young men spending far too much time in their cells with no purposeful activity. Two days after the man's death, Her Majesty's Chief Inspector of Prisons (HMCIP)

began an announced inspection there. I share the concerns expressed in her report published in May 2005.

The Investigation Process

I was notified of the man's death on 13 February 2005. My investigators visited the prison and saw the cell where he died. They reviewed all the relevant prison records and established a chronology of events. They also visited the local police station and spoke to a Detective Sergeant who was involved in the police investigation. Subsequently, I personally visited the prison and spent some time with the Governor.

Notices were issued to staff and prisoners announcing the investigation and offering them the opportunity to contribute to it. My investigators contacted the Chairman of the local branch of the Prison Officers' Association (POA), and the Chair of the Independent Monitoring Board (IMB) to tell them about the investigation. My investigators visited Brinsford on five occasions during the course of the investigation. Twenty members of staff and nine prisoners were interviewed.

My investigators also contacted the man's key worker at Compass (a young people's drug and alcohol service). During the course of their first visit to Brinsford, several staff told my investigators that they were concerned about elements of the cellmate's account of what happened on 12 February. Amongst those were two officers, who have many years of service between them, the Chaplain and the Suicide Prevention Officer. I agreed that an approach should be made to the police alerting them to the concerns of these experienced staff and asking whether they would re-interview the cellmate on tape. Despite several phone calls and a meeting with a senior officer, the police declined to speak to the cellmate. Regrettably, they also decided that my investigators should apply to the Coroner for copies of the statements taken during their investigation (it is far more usual for the police to provide copies of their statements direct to the investigators). This process took some months and resulted in a considerable delay in the investigation.

A copy of the post mortem report and toxicology report was obtained from the Coroner. The post mortem showed the cause of death to be "cerebral anoxia due to hanging". The toxicology report was eventually received in July 2005. It showed that the man had taken a sleeping tablet before he died but the levels of the drug in his system were not sufficient to have had an impact on his death. A specialist in substance misuse was then commissioned to carry out a clinical review.

My investigator and one of my Family Liaison Officers, met with the man's mother, step-father, grandmother and partner. I am most grateful to them for having this meeting at what must have been a very difficult and distressing time. Regular contact with the man's mother was maintained throughout the investigation.

Background
HMYOI Brinsford

Brinsford opened in 1992 as a remand centre holding young offenders awaiting trial and transfer to training establishments. As a consequence, it was built without workshops. Following a change of role in 2000, it now operates as a split site holding remand and sentenced juveniles on two units and young adults remanded for trial or sentence on two others.

The most recent HMCIP report, published in May 2005, highlighted the fact that the YOI was split awkwardly into separate facilities with neither having sufficient activities to occupy the young offenders held there. HMCIP found an establishment, "struggling to provide appropriate levels of safety, respect and even basic cleanliness".

Work with prisoners with drug issues is undertaken by CARATS workers. Although 80 per cent of the young offenders go through detoxification, there is no specific detoxification unit.

The man's time in Brinsford from 27 January to 11 February

(i) Interaction with staff

The man spent the night of 26 January 2005 in a Police Station. He was seen by two health workers including a forensic medical examiner. The first health worker recorded a history of self harm and recent drug abuse including heroin and crack cocaine. This information was obtained from the man during interview.

The man was remanded into custody from the Magistrates' Court on 27 January 2005. He was charged with shoplifting and obstructing a police officer. He had been in Brinsford on three previous occasions, most recently between 26 and 30 November 2004. On each of his previous periods in custody, he gave the name he had used for most of his life, however, this time he used the name on his birth certificate.

The man's records contain a single Prisoner Escort Record form (PER – the form which travels with a prisoner each time they make a journey), for the journey between the Police Station and Magistrates' Court. There is no PER for his journey between Birmingham Magistrates' Court and Brinsford. The PER completed at the Police Station indicates that the man's risk areas were drugs and suicide and self harm. There is no additional information on the form to explain the nature of this risk as there should be.

On arrival at Brinsford, the man went through the usual reception process. All young offenders arriving at Brinsford, whether they have been transferred in from another prison or have come directly from court, are seen by staff from the Induction Throughcare & Support Unit (ITSU). Each prisoner is seen by an officer who completes a First Night in Custody Form. This is designed to identify potential areas of risk or concern. The young men are then seen by a nurse who completes a full health assessment and who will refer them to specific services if deemed necessary. All new arrivals are than located on the ITSU. The following day, they see representatives from several agencies that will help with housing, drug issues, jobs, family problems, and any other problem that has been identified by the initial assessment.

An officer completed the man's First Night in Custody Risk Assessment. Based on the responses to his questions, he decided that the man was suitable for location in a multi-occupancy cell. The form indicates that the man told the officer that he was not worried about anything. The officer wrote:

> "The man has been in Brinsford previously and has experience of the rules and regime, the man has tried self-harm and suicide before some three years ago, hanging, jumping from a bridge. Appears calm and states no thoughts of self harm at moment. Would prefer a single cell. Recently became a father for the second time. No contact with parents, lives with grandmother."

At interview, the officer who completed the risk assessment form said he remembered the man telling him that he attempted suicide by jumping off a bridge a few years previously. The officer commented that the man had told the story in an amusing way, saying he "had missed" and that he was smiling.

The man was then seen by the probation officer, who also noted his previous attempts at suicide and self harm, and detailed the particulars of his drug taking. He also mentioned that the man was undergoing tests for frontal lobe epilepsy. He noted on the record:

> "No particular worries about being in custody again, feels he will cope ok."

On the same evening, the man was seen by a Nurse who completed his reception health screen. The man told her about his drug use and also said he suffered from asthma and chest pains. In terms of his drug use, he again disclosed his use of heroin, crack and methadone. When asked about his mental health, he explained that he had taken medication (Fluoxetine, i.e. Prozac) about two years previously. He also spoke about an episode of self harm outside prison three years earlier when he said he cut his wrists. The Nurse then asked the man about his current potential for self-harm and he said that he did not feel like that and did not wish to see a doctor for any reason. The care plan drawn from this assessment referred the man to the Care, Assessment, Referral and Treatment (CARAT) team (the team in Brinsford who deal with prisoners who have drug issues). He was also referred for a mental health assessment.

The man's core record begins on the same date, 27 January. The officer that completed the risk assessment noted in it the man's history of self-harm and drug taking, and added that the man had appeared calm and happy during his interview with him. The officer who completed the risk assessment added:

> "Not enough concern at moment to place on F2052SH, monitor for self harm and state of mind, possible epileptic (tests at QE Brim) [sic]."

The man also had a urine test on his first evening which tested positive for benzodiazepines, cocaine, methadone and morphine (heroin). He was seen by a doctor on 27 January when a 14 day subutex detoxification was prescribed, beginning the next day. The man was also prescribed Zimovane (generic name Zopiclone, a sleeping tablet) for seven days. He was issued with his first tablet that night by another Nurse as part of the standard detoxification procedures. Additionally, he was given a ventolin inhaler for his asthma. The man requested vaccinations for Hepatitis B and Meningitis C and received these on 2 and 9 February.

The man then moved to a cell on the ITSU where he spent his first night. Having been referred to the CARAT team, he received his induction the next day. His assessment was carried out. The man confirmed that he used heroin on a daily basis along with prescribed methadone and illicit methadone. He also said he smoked cannabis and crack cocaine. He gave details of

previous treatments he had sought using prescribed methadone. He said he had also completed a subutex detoxification programme during his previous time he was in Brinsford in 2004, but had relapsed on the day of release.

The man agreed that the CARAT assessment officer could contact his probation officer and his Drug Treatment & Testing Order (DTTO) worker. The plan was to apply again for such an order and the man booked a legal visit for 11 February to complete the related paperwork.

Later on 28 January, the man completed his prison induction and the next day, 29 January, he moved to E wing and was given a job working in the kitchen.

The man attended the Healthcare Centre every morning to receive his subutex. He was given his medication in a room under the supervision of two members of healthcare staff. The tablet is dissolved under the tongue and staff would watch while he took it. He was then given his sleeping tablet for that evening, in a sealed bag. This medication was issued each morning until the prescription ended on 2 February 2005.

On 4 February, along with two other prisoners, the man was sacked from his job in the kitchen. All three had reported sick that day and said they could not work because of the side effects of their subutex programme. The man was transferred to G wing the same day. G wing is the wing where prisoners without jobs are located.

The next day, 5 February, the man's wing file states that he appeared quiet and had not come to the attention of staff.

According to his Inmate Medical Record (IMR), the man was due to see a Registered Mental Health Nurse (RMN), for his mental health assessment on Sunday 6 February, but this was rescheduled for the following week because of staff shortages. The RMN discussed the postponement of this appointment with her line manager, as such assessments were usually only conducted on weekdays. Staffing levels on weekends are much reduced. The man did not have his appointment before he died.

The next and final entry on the man's wing file is dated 12 February. The comment reads that he was, "still keeping his head down, no problem to staff, only speaks when spoken to and is polite enough".

(ii) Contact with his family

The man's partner visited him twice. The first visit was on 3 February and she went alone. She said the man looked depressed and told her, "I am going to kill myself. I might as well. I can't see my kids. It will be better for everyone if I was out of their lives." She said she reassured him that his mother and all his family loved him and promised to bring the children to see him the following week.

His partner visited the man together with their two children and a social worker on Thursday 10 February. She said the man was in better spirits because he was happy to see his children. She said he talked about giving up drugs and said he wanted his family back. His partner said she told the man that nobody hated him and they would try to help him. She said nothing about his behaviour causing her concern on this visit. He told her he had a new cellmate and that he made him laugh. They talked about arrangements for his appearance at the Magistrates' Court the following week.

His partner also wrote to the man and had two phone calls with him while he was in Brinsford.

In the week before he died, the man received a letter from his mother and then, on Friday 11 February, one from his grandmother. Both letters made it clear that they loved him but told him how much his drug taking had caused distress to the family. His grandmother told him that he would not be able to live with her on release because she was scared by his behaviour. Both said they were at their wit's end and urged him to take control of his life and get help for his addictions. His grandmother said she hoped her letter would shock him into sorting his life out.

(iii) What other prisoners said

A prisoner worked in the kitchen with the man and was sacked at the same time. He said that he, his cellmate and the man had been ill from their medication on the same day. However, staff had not believed them and they were sacked. They were all moved from E to G wing as a result. He said that he knew the man from their time on the juvenile unit a couple of years previously. The prisoner who worked in the kitchen said he also knew the man by his street name. The prisoner who worked in the kitchen said that he thought that the man had coped with being in prison. He had never told him that he could not cope nor that "things were getting on top of him".

The prisoner who worked in the kitchen said his symptoms included vomiting and a headache. He said he told Healthcare staff because he felt so ill and thought it was the subutex programme. He believed his symptoms got worse towards to the end of the two week detoxification period. He was later given the job of landing cleaner and moved into cell number 1 and the end of G2 landing.

Another prisoner said he had known the man since the age of 13 when they were in the same class at school. He said he saw the man a few days after he arrived in Brinsford and spoke to him for a short while. He said they chatted about school and the man had seemed "alright, himself really". He said he bumped into him on five or six further occasions but did not see him on association as they were on different landings. He said he talked to the man at night by shouting from his cell window. He said the man seemed fine most of the time, but had told him that he was coming off drugs and this was affecting him. He said he did not think the man was being bullied in Brinsford because he thought he would have told him if he was.

A third prisoner was on his own in cell G2/20 next door to the man. He said that he used to talk to the man through the heating pipes which run between the cells. He said that the man had told him that he had been on remand several times before and the prisoner next door thought that he was coping with being in prison. He said that the man told him that he was due in court on 17 February, and was expecting a further three weeks remand, but was hopeful that after that his probation officer would get him released on a detoxification programme. He said he did not notice any change in the man's behaviour during the week before he died and said he seemed fine.

The man's cellmate was remanded into custody from the Magistrates' Court and arrived at Brinsford on Thursday 3 February 2005. After induction, he was allocated to share cell G2/19 with the man. In a statement made to the police on 14 February, the cellmate described the man as "an ok type of guy". He said they got on well together, that the man could be a bit mad but made him laugh, and that they used to talk together. The cellmate said the man also used to talk though the pipes to the other lads in the cell next door. He said that the man was "the same sort of person for the week or so that I knew him".

The cellmate said the man used to talk about his girlfriend and his children a lot. He also read his cellmate some of the letters he received. He described one which the man had received from his mother and said that he had been "pissed off" and "angry" and had punched the wall with his fist. His cellmate said the man also talked about a letter he had received from his grandmother in which she had said he could no longer live with her. His cellmate said the man was "gutted", but he felt that this was because he would have to find somewhere to live.

His cellmate said the man had a domestic visit on Thursday 10 February with his girlfriend and children. He said the man had told him that he had a legal visit booked for the same time but had chosen not to attend so he could see his family. The man did have his legal visit the next day, Friday 11 February. After this, his cellmate said the man talked about getting on a drug programme or writing a letter to the court to try to get early release. His cellmate said he seemed fine and had gone on to talk about playing football on Sunday at gym time.

What happened on 12 February

(i) From morning unlock to early evening lock down

On the morning of 12 February, the man went to see a member of healthcare staff complaining of toothache. He was given a painkiller and went back to his wing. Later that morning a prisoner on the man's wing, said he saw him when they both were using the showers. He said that the man "looked okay".

Several other prisoners saw the man during Saturday 12 February during the association period between 3.00 and 4.15pm. The prisoner who worked in the kitchen saw the man on association that afternoon. He described him as "happy" and said he "was joking". He said the man "did not give me the impression that anything was bothering him".

A fourth prisoner also saw him on association that afternoon. He said the man was laughing and joking and telling stories of scrapes he had got into. He said the man told him that he was "rattling" (withdrawing from drugs) because he had finished his medication, but that he "seemed to be alright". He said he talked to him and his cell mate and they seemed to "get on alright".

A fifth prisoner did not know the man very well, but saw him on association that afternoon laughing with his cellmate and the fourth prisoner. Another prisoner said he knew the man because he shared a cell with him when the man was in Brinsford in 2002. He said he saw the man on association and he was "having a laugh" and "seemed fine".

A sixth prisoner said he knew the man from outside prison. He said he had laughed and joked with him on association and he did not appear to be having any problems in prison. He said the man told him he was "rattling" but he had laughed it off and he did not think there was anything wrong with him.

The man's cellmate said he spent most of his time on association with someone he recognised from his home area. He said he did see the man talking with three lads who had 'Brummie' accents. He said there did not seem to be any problems.

His cellmate said that, after association, he and the man went back to their cells, collected their tea and took it back to their cells to eat. After tea, the landing cleaners came round and each person emptied their bin into bin bags and gave their meal trays to the cleaners. The prisoners were locked in their cells at about 4.30pm.

The prisoner who worked in the kitchen, was still out on the landing with the other landing cleaners, spoke to the man through his cell door. He said the man told him he was "rattling" and could not sleep. He told him that he had not had any sleep for almost three days and had finished his medication and was withdrawing from the subutex. In interview, the prisoner who worked in the kitchen said that he believed that if he had been planning to do anything he would have said something to him. He said the man also told him he had

"a sleeper" (a sleeping tablet). He said otherwise the man seemed to be himself. The prisoner who worked in the kitchen said that this conversation with the man took place shortly before he was 'banged up', which would have been at about 7.50 – 8.00pm.

The cellmate of the prisoner who worked in the kitchen said he also spoke to the man through the door of his cell and that the man had said he was withdrawing from drugs and had not slept for two or three days. He said that otherwise the man appeared to be okay and he was not concerned for him. A landing cleaner said he also talked to the man at this time and remembered him saying he had a "sleeper" because he was "rattling".

An officer said she finished checking that all of G2 landing was locked up at about 7.40pm. She said she did not know the man as she was relatively new on the landing. She said no prisoners raised any concerns with her during lock down.

The prisoner next door to the man was in cell 20 on G2 landing. He said that, at approximately 8.00pm, they were locked up for the night and he began talking to the man through the 'pipes'. The prisoner next door said the man told him that he had a sleeping pill. When he asked the man where he got it from, he told him that he had swapped it with someone on the landing for a chocolate bar.

The prisoner who was in the same class at school with the man said he shouted to the man through his window after they were locked in their cells between 8.00 and 8.30pm. The classmate's cell was on the landing below the man. He said the man had shouted to him that he was "really stressed". The classmate said he had asked him why and he had said,

> "My mum and dad left me. The only person I had in my life was my grandmother and now she's left me."

He said the man repeated that he had "no-one" and told him about two letters he had received from his mother and his grandmother "disowning him". The classmate said he was worried about the man because he seemed "so upset". He thought that the man's mood was not helped because he was coming off drugs. The classmate said the man asked him for some tobacco which he sent down "a line" to the cell below. He said the tobacco was then taken to the man's cell by the landing cleaner. (This puts the conversation before 8pm when the cleaners were locked in their cells.) The classmate said he later heard the man shouting to someone else to arrange for a sleeping tablet to be sent to him in exchange for a cigarette.

(ii) What the man's cellmate said

(a) On the night of 12 February 2005

An officer spoke to the man's cellmate in the wing association room where he was first taken while staff worked to resuscitate the man. The officer said the

cellmate told him that he had removed the ligature from around the man's neck. He said the cellmate told him that he had "bumped into" the man as he was getting off of his bed, removed the sheet, found that he was not breathing and pressed the cell bell. The officer said he made the cellmate cup of coffee and that the cellmate was upset.

The cellmate was spoken to by a Detective Inspector and Sergeant of the police at 1.45am on 13 February. Also present was a Senior Officer (SO), the Suicide Prevention Co-ordinator at Brinsford. The Detective Inspector and Sergeant both gave the following account of their conversation with the cellmate in statements made on 27 and 20 April respectively:

> "[The Sergeant said] '[the cellmate] can you tell us what happened last night in your cell after lock down?' He replied, 'Yeah I woke up and found him hanging, he was blue with his tongue hanging out. I untied him and took him down then I pressed the cell buzzer to get help.' [The Sergeant said] 'Thanks [the cellmate], you said he was hanging can you tell us how and where from he was hanging?' He replied, 'Hanging off the top bunk with a sheet tied round his neck. He was sort of sitting off the edge of the bed.'
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> "[The cellmate] then demonstrated how [the man] was at the side of the bunk using a training bed that was in the room. He went to the side of the bed one third of the way down the bed from the headboard, put his back to the bed and squatted down with his bottom about 12 inches off the floor, his legs out straight and told us his hands were down by his side. His head was to one side his left and his tongue was hanging out."

The cellmate also told both police officers that the man had been "quiet" for the "last few days" and had taken a sleeping tablet that night. I have not seen any other police record of this conversation with the cellmate.

The Suicide Prevention Officer told my investigators that he first attempted to speak to the cellmate at about 1.00am but he was not co-operative. He said that, about 1.45am, the police requested that he accompany them when they spoke to the cellmate. The Suicide Prevention Officer said that the cellmate told the police that he had gone "fast asleep" on his bed for "about ten minutes" before he woke up needing to go to the toilet. He said the cellmate explained how he looked over the side of the bed and saw the man hanging off the side. He told the police he got out of bed and saw the man had tied his bed sheet under the top bunk and then put it around his neck. The Suicide Prevention Officer said the cellmate demonstrated the position the man was in by using a "mock bed" in the classroom. The Suicide Prevention Officer said the cellmate showed them that the sheet was fed up though the metal slats underneath the mattress on the top bunk. He said the cellmate said that he untied the sheet from under his bed, took it from around the man's neck and put the sheet on the bed. He said the cellmate said he felt for a pulse and when he could not find one he decided to raise the alarm.

The Suicide Prevention Officer said, in his opinion, based on his experience and given the description offered by the cellmate, he found it difficult to believe that the man could have tied the sheet to the bed without disturbing the upper bunk and also that it would have been extremely difficult to untie the knot in the sheet.

(b) In his police statement of 14 February 2005

The cellmate said that, after tea, the man was a bit "quiet" but then he started talking to someone in the next cell. The cellmate said he was lying on the top bunk on top of the covers. He said the main light and the TV were on in the cell. At some point he said they were checked by a short member of staff with a goatee beard and soon afterwards he fell asleep. He said he was not intending to sleep as he was still fully dressed. He also said he remembered that, sometime between being checked and falling asleep, the man had mentioned that he had taken a 'sleeper'. The cellmate said he remembered seeing an empty blister pack by the TV and assumed that this was where the pill had come from. The man had told him he had swapped it for a chocolate bar.

The cellmate did not know how long he had been asleep but he guessed it was somewhere between a half an hour and an hour. He said the cell was in semi darkness when he woke up. The cell light was off but the TV was on. The cellmate explained that he started to get down from his bunk to use the toilet when he noticed the man was sitting on the side of his own bed. Had he continued, he would have hit him. He said he looked down at the man and realised his head was slumped to one side and his legs were stretched out in front of him, wide apart. The cellmate said that the man just seemed to be sitting there, so he moved to the bottom of his bunk bed and got down from there. He said it was then that he noticed the sheet wrapped around his neck and tied to the top of the bunk bed frame.

The cellmate said he moved closer to the man and saw that his tongue was hanging out, his face was pale and his arms were "flopped" by his sides. He said his bottom was suspended up in the air and he was "still, motionless and made no noise". He said he began to panic and called out the man's name and then started to undo the sheet. He said the sheet was wrapped around the "tube pipe" of the upper bunk bed and then tied in two knots under the bunk. He explained that the knot was hard to undo. Eventually, he undid the part secured to the bunk bed and, as he did this, it unravelled and shot though his hands. He said the man then fell onto the floor hitting his head. He then undid the part of the ligature that was around his neck. He said it was a lot easier to undo the sheet, which was again knotted twice, from the man's neck. The cellmate said he threw the sheet onto the man's bunk bed, and began slapping him about the face looking for a reaction but there was none. He then rang the cell bell.

The cellmate said he returned to the man and lifted one of his eyelids twice. He said no-one had responded to his buzzer, so he rang the cell bell for a second time and "started to make as much noise as I could" by banging the

cell door. An officer then came to the door and looked in though the observation window. The cellmate said he then shouted, “Look, look, he’s hung himself.” He said the officer told him to wait a minute and moved up the corridor. The cellmate said at this stage he did not know what to do. He said he sat on the bottom bunk and began to cry. He explained that he was not first aid trained and described himself as shocked. He said the officer returned to the cell door and, as he heard the key in the lock, another taller officer arrived. The cellmate said the taller officer first attempted to move the man using his foot and then picked his arm up twice before letting him fall to the floor banging his head. He said this officer then used his radio to call for an ambulance.

The cellmate said a nurse arrived a few seconds later and went straight to the man. He was told to leave the cell and was taken to the Association Room at the end of the landing before being taken to the Healthcare Centre.

(c) In interview on 10 January 2006

The cellmate said that he could not remember speaking to the police on the night the man died. He said he remembered telling the Suicide Prevention Officer and the Chaplain that he did not want to speak to them but had no memory of speaking to the police. The cellmate said the man spent a lot of his time talking to other prisoners out of the window and through the door of his cell. He said the man seemed to know other lads in Brinsford and he used to spend his time watching TV and smoking. He said he and the man used to talk about what they were in prison for and that he “just seemed normal to me”. He said the man was “proper energetic” and “loud”. He said they had a good laugh and he thought he seemed to be quite happy. The cellmate said that the man had become angry when he received a letter from his mother or his grandmother but he was not generally angry.

His cellmate said that the man was “stressed” by his detoxification and had bought sleeping tablets and tobacco while on the wing. Despite this, his cellmate thought the man seemed “generally alright” and he said he had not seen any real change in him during the week they spent together. The cellmate said he was not keen on sharing a cell with a heroin user and had asked a member of staff if he could move cells while the man was on a legal visit on the day before he died. He said the member of staff had ignored him. He said he did not think the man knew he had asked to be moved. His cellmate said the man had helped him to settle into the routine at Brinsford, showed him what to do and had been friendly to him.

The cellmate said he remembered talking to a friend of his from home during association on the afternoon of 12 February. He could not remember the man being quiet after they had eaten their evening meal. He said he did remember him taking a sleeping tablet because he remembered that the man had accidentally dropped one down the toilet and had been “gutted”. He said he remembered that the TV had been on and there was nothing very good on it. He said he turned over so he was facing the wall and went to sleep. He could not remember how long he had been asleep, but he “could sleep all day and

all night long" and had thought it must be morning when he woke until he noticed that the TV was still on. The cellmate said he remembered waking up, rolling into a sitting position and getting out of bed at the end of the bed. He said he flicked the light on, went to the toilet and turned round to see the man suspended from the bed.

He said he took a step towards him and asked him if he was alright. He said he did not get any response so he started ringing his bell, shouting and banging and kicking his door. The cellmate said he was certain he had gone to the toilet before he saw the man. He said the man's bottom was suspended about a foot off the floor and his legs were sticking straight out in front of him. His hands were also on the floor. He said the ligature was tied to the main frame of the bed and would have to have been pushed up under his mattress. He said the man was blue and he could tell that he "was gone".

The cellmate said that the night officer (the OSG) responded to his bell after "two or three minutes". He said the officer came to the cell door and he told him the man had hanged himself. He said the officer looked through the door and went down the corridor to use his radio. He said the officer came back and asked him to untie the man before he opened the cell door. He said he thought the sheet went over the main frame of the bed twice and then was tied twice underneath. He undid the top knot, which was very difficult and took some time, and the sheet unravelled and the man went to the floor. He said he remembered that it was easier to untie the knot from around his neck and he threw the sheet on to the bed. He then ran to the door and the officer opened it.

The cellmate said that the OSG was on his own outside the cell when he asked him to untie the man. He said he did not come into the cell but waited for other officers to join him. They then opened the door and several of them entered at once. He said a tall bald officer came into the cell and lifted the man up by his arm and let his head fall to the floor two or three times. He said he was standing in the cell when this happened but then a nurse came into the cell and told the officers to get him out of there. He said he was taken to the Association Room at the end of the corridor and then taken to the hospital. He said he spent the night and the remainder of his time in Brinsford on the ITSU.

In responding to the draft version of this report, the OSG was adamant that when he looked into the cell there was no ligature around the man's neck and therefore he did not ask the cellmate to remove it. He also disagrees with the cellmate's comments regarding the Night Orderly Officer's 'rough handling' of the man's body. He said that the man was handled with great care, and that everything was done to revive him. The OSG said that resuscitation could not begin until the man was in a suitable position, but he was moved as soon as possible, and resuscitation then started immediately. The OSG's account of that evening is detailed below but it should be noted that his version and that of the cellmate do not always match.

I do not draw any conclusions from these differing accounts except to say that each person involved in such a major event will remember it slightly differently, especially in such traumatic circumstances, and it is difficult to say which is the more accurate.

(iii) From when the alarm was raised to when death was pronounced

Operational Support Grade (OSG) arrived for his night duty at 7:55pm. He said he began checking G2 landing at about 8.05pm, and then moved on to check G1, E1 and E2 landings. All the cells are checked to make sure the doors are locked and the correct numbers of prisoners are present. After making his checks he returned to the central office to do paperwork. At about 8:35pm or 8:40pm, he said a cell bell rang and he answered it. He remembered that the prisoner had wanted a painkiller. He said he then returned to the office and another cell bell went off at about 8:55pm.

He said that the board indicated that the bell had been rung on G2 landing. He said he left the office immediately and, as he approached G2, he heard kicking and banging and someone shouting, "Boss he's hung himself." When he got to the cell door, he opened the flap and saw the man's cellmate standing by the toilet on the left of the cell and the man on the floor of the cell lying on his back with his head towards the door. He said he could see that the man's face was blue and he was motionless. He said he realised that medical assistance was required and moved a few yards down the corridor to use his radio to call for help. He said he moved away from the cells because it was quieter.

The OSG said he went back to the cell door and thought about whether to enter the cell alone. He said that his training had made him aware that in some cases prisoners could be bluffing in order to get keys. He said he decided to go in and called on his radio to say he was about to do so. He then shouted to the cellmate to stand aside, opened the sealed pouch containing the cell key and entered.

The OSG said that the man was blue in colour and his eyes and mouth were open. He could not remember seeing his tongue. He said that, as he bent over him, the Night Orderly Officer (the officer in charge of overseeing the running of the prison during night duty) entered the cell. He said the Night Orderly Officer, "sort of stepped over and grabbed the lad and I saw his head hit the deck". He said the nurse then entered the cell, turned the man over and began cardio pulmonary resuscitation (CPR). The OSG said that he thought it was obvious that the man was already dead at this point. He said that the Nurse continued to work on the man and the Night Orderly Officer held the oxygen bag.

The OSG said that the paramedics arrived after a while and they moved the man out onto the corridor to have more room to work on him. The OSG said he noticed that one of the cells next door had no cover on the observation hatch. He said he removed a sheet from the bottom bunk in the man's cell and used it to cover the observation hatch so that the prisoners inside could not see the paramedics working on the man. He said that he remained there until the Night Orderly Officer told him to go to the Healthcare Centre and he was relieved by another officer.

The OSG described the sheet he removed from cell G2/19 as green in colour, “folded lengthways and then in half, making it in a strip”. He said it looked as if it had been thrown on the bed. He said he did not know what happened to the sheet after he left the wing. He said he thought when he was in the Healthcare Centre that he had not seen an obvious ligature in the cell.

The Night Orderly Officer said he was in the Gate area when he received a call for assistance on his radio at about 9.00pm. He said he made his way to G2 landing immediately and simultaneously told an officer to go to the Healthcare Centre and collect a nurse. On entering cell G2/19, the Night Orderly Officer said he saw the OSG and the man’s cellmate standing in the cell. He said the man was lying on the floor of the cell face up. He said he checked to see whether the man was conscious and immediately called for an ambulance and turned him onto his side. He remembered that the man did not appear to be breathing.

The Night Orderly Officer said that a “few seconds” later the nurse and the officer he sent to get her entered the cell. The Night Orderly Officer said that the Nurse began chest compressions and he administered oxygen to the man via a facemask. He said they continued to work on him for 10 to 15 minutes and then the paramedics arrived. He said the paramedics moved him into the corridor as there was more room to work on him. He said they worked on him for a further 35 minutes and then pronounced him dead.

The Nurse said she was giving out medications when she heard a call over the radio for medical assistance. She said she was not given any detail about what type of emergency it was, so she gathered her emergency bag and waited to be picked up by an officer who had keys. She said an officer came to collect her after a couple of minutes and they ran to G2 landing. This took about another 90 seconds to two minutes.

When she arrived at cell G2/19, she saw the Night Orderly Officer, the man’s cellmate and the man who was lying on the floor on his side. She said the cellmate was crying and she asked him to leave the cell. The Nurse said she turned the man on to his back and felt for a pulse. She could not find one and said he was “cyanosed” and grey in colour. She said she started CPR and the Night Orderly Officer administered oxygen using an ‘Ambubag’. The Nurse thought that she worked on the man for around 15 minutes before the paramedics arrived. They decided to move him into the corridor but she continued to work on the man to maintain his airway. She thought that the paramedics worked on him for a further 30 minutes before pronouncing death.

The Nurse said she noticed a bed sheet on the lower bunk which “was folded in a way that it could be used as a noose”. She described the sheet as having no knot in it and said it was folded about six inches wide.

An officer was working nights in Residential Unit 4, the opposite side of the corridor to G2. He explained he had come on duty and done his checks, and was going up to the centre office from one of the landings when he heard the request for assistance over the radio from Residential Unit 3 at about 8.50pm.

The officer from Residential Unit 4 explained that at night you are locked onto your landing and only carry an emergency key which allows you to open up a cell in the case of emergency. He said that only the Night Orderly Officer and the Assist Night Orderly Officer carry keys. He said he then heard the OSG use his radio to say he was going to enter the cell.

The officer from Residential Unit 4 said the assist Night Orderly Officer opened the door between the Units and he went straight to G2/19. He said that, when he reached the cell, a nurse was already there doing chest compressions while the Night Orderly Officer was at the man's head using the oxygen bag to give him air. He said he did not see a ligature at this point.

The officer from Residential Unit 4 was then asked by the Night Orderly Officer to take his keys and go downstairs to open up the way for the ambulance staff to come though. Just as he was doing this, the paramedics arrived and he and the assist Night Orderly Officer escorted them up to the cell.

The officer from Residential Unit 4 said he noticed that there were two cell cards by the door of cell 19, which indicated there was another person in the cell with the man. He asked the Night Orderly Officer where the other person was and was told he had been put in the small Association Room at the end of the wing. The officer from Residential Unit 4 said he asked the cellmate where the ligature was and he told him that it was on the bed and that it was a sheet.

The assist Night Orderly Officer said he came on duty at 8.00pm. At about 8:55pm, he heard a radio message saying medical emergency. He said both he and the Night Orderly Officer left the gate immediately; the Night Orderly Officer went directly to G2 and the assist Night Orderly Officer went to the Healthcare Centre to collect the Nurse. He escorted the Nurse to cell G2/19 where he noticed that the man's cellmate was looking visibly upset. He took the cellmate to the small association room. The assist Night Orderly Officer said he then returned to the gate and opened it to ensure the ambulance had easy access. When the ambulance crew arrived he escorted them onto the landing and returned again to the gate as another ambulance had arrived. He took the second crew up to G2 landing and remained there while they worked on the man until they pronounced him dead at 9:50pm.

(iv) What other prisoners heard

The prisoner that occupied the cell next door to the man, G2/18 shared the cell with another prisoner. His cell had no privacy shutter on his observation hatch and he said he could see the officers going into the man's cell on the night he died. He said he heard the cell bell go off and heard someone banging on the door. He saw an officer go to the cell and wait for permission to go in. He then saw the man's cellmate leave the cell. He said that it was not noisy on the landing at that time.

The other prisoner in G2/18 said he was in his cell listening to music when he heard banging and shouting coming from the cell next door at what he thought was about 10.30pm. He said he went to his cell door and shouted for everyone to shut up. He said he heard someone shout, “He’s hanged himself.” He said he went back to listening to his music and went to sleep.

The fourth prisoner from association was in one of the cells opposite to the man’s cell. He said he thought he heard a cell bell at about 8.00pm and saw an officer go to the cell door. He heard running steps and saw the nurse arrive. At that point, he said another officer arrived and closed the privacy shutter on his cell. He later saw the man’s body lying in the corridor through the crack in his door and watched while the paramedics worked on him for about “45 minutes”.

The fifth prisoner from association was in cell G2/17, the cell next door but one to the man’s. He said he was talking out of his window when he heard the man’s cellmate banging and shouting for a “boss” (a prison officer). He said he thought this was about 9.30pm. He said the cellmate was ringing his buzzer and shouting that his pad mate had hung himself. He said he was shouting over and over and he seemed panicked and crying. The fifth prisoner from association said he heard the officer say to the man’s cellmate, “let me have a look” or “move out the way”, and then he went away. The man’s cellmate started shouting again and the officer came back a minute or so later. The fifth prisoner from association said he was suddenly aware of several officers arriving, running down the landing and the landing lights went on. He said after about 20 minutes the paramedics arrived and the man was moved into the corridor. He could see him lying in the corridor and the paramedics working on him for about 30 minutes. His privacy shutter was then closed.

The prisoner in the cell opposite the man’s, said he was watching *Casualty* on his TV when he heard a cell buzzer go off. He thought this would have been some time between 8.30 and 9.00pm. He said he looked through the crack between his door and the wall and could see a light flashing outside cell G2/19. He said he heard the cell door being kicked from the inside. He said that, shortly before the cell door was opened, which was about two minutes after he heard the buzzer, he heard someone shout “He’s hanging.” The prisoner in the cell opposite the man’s said he watched as the door was opened and “a number of” officers went inside. He said he could see the man’s legs and the officers standing over the body.

The prisoner in the cell opposite said that, “after a while”, the paramedics arrived and the man was taken out of the cell and onto the landing. He said he could not see much after that but remembered hearing what he described as a bleeping noise and a pumping sound. At some point later, he heard someone say, “His heart is only beating because of the adrenaline”, and then, “Are we all in agreement he is dead?” He said the landing light was then switched off. He later saw the police arrive and he went to bed about 12:30am.

The prison's immediate response to the man's death

A Principal Officer was going off shift at 9.00pm when he heard the call for assistance. He returned to the main prison building and went to the communications room where he helped a second OSG work through the death in custody contingency plan and complete the communications room action checklist.

The Governor on duty, on Saturday 12 February, received a phone call from the prison at 9.50pm and was informed that a young man had been found in his cell and the paramedics were in attendance. He was given details of the staff that were involved and said that during the call he was told that the man had been pronounced dead. He told the communications room that he would be back at the prison in about twenty minutes and arrived outside the gates at 10.20pm.

The Duty Governor said that as he got to the gate he had to wait for about five minutes to be let in. As he was waiting, the police arrived. As both he and the police were being let through, a second police car arrived and that too was admitted. The Duty Governor explained that he arranged for the police to be taken directly to G2 landing and he went to the communications room to check what action had been taken.

The Suicide Prevention Co-ordinator, arrived at the prison about 10.45pm. When he arrived at the gate, he was briefed and then went into the communications room where he was asked to search on the LIDS system for information relating to the man. The Suicide Prevention Officer found that the man had been in Brinsford before under the name he had used for most of his life, and had been subject to self-harm monitoring.

The communications occurrence log is kept by staff in the gate who are responsible for monitoring and relaying radio messages. The log shows that at 9.05pm an emergency call was received from radio call sign Charlie 8 (the OSG) from G2 landing. At 9.07pm, a further call was made from Charlie 8 to say that he was going into cell G2/19. At 9.09pm, radio call sign Oscar 8 (the Night Orderly Officer) requested an ambulance and 999 was dialled immediately. The log shows that, by 9.11pm, the assist Night Orderly Officer had arrived at the gate to escort the ambulance. The ambulance arrived at 9.18pm and the paramedics were in cell G2/19 at 9.25pm. The senior police officers arrived at 11.34pm and 11.51pm. The man's cellmate was unlocked for interview at 1.40am.

A scene attendance log was commenced at 10.35pm. The log showed that the paramedics arrived on G2 landing at 9.25pm and left the prison at 10.40pm. The log also showed that Scenes of Crime Officers arrived at 11.40pm and 00.20am. An officer with responsibility for scene preservation arrived at 1.00am, and the undertakers arrived at 3.05am.

The communications room action checklist shows that the police left the prison at 3.15am and took with them the letter from the man's grandmother.

The man's body was removed from the prison at 3.25am. The checklist shows that the Duty Governor, National Operations Unit, the Governor, the Area Manager, the IMB and the Care Team were all contacted in a timely manner.

The Duty Governor asked the Night Orderly Officer to seal the cell with a unique lock at 10.45pm. The area was treated as a potential crime scene and steps were taken to preserve evidence. The Night Orderly Officer said the police told him that the man's body was not to be removed from the landing. He said he was concerned that this would upset prisoners and staff. The man's body was eventually moved further down the landing once the Scenes of Crime Officers had finished their work.

After the paramedics left the prison, the Night Orderly Officer and the Duty Governor went onto G2 landing. The Duty Governor said he checked on the staff involved and also ensured the other prisoners on the wing were checked. He said he held a hot debrief at about 5.00am. The Care Team were available to speak to staff. The next day, the Chaplain visited the other prisoners on the wing.

All staff involved were asked to submit statements and the majority were interviewed by the police. Notices to prisoners and staff were issued the following day. Both notices made it clear that support was available for anyone affected by the man's death.

Contact with the man's family

The police contacted the man's grandmother who he had given as his next of kin. The Duty Governor called her after the police had confirmed that they had broken the news her. This was at about 3.30am. He said he explained that he was aware she lived alone and wanted to ensure she was alright. He also explained about what would happen in terms of liaison with the family and offered her the opportunity to visit the prison should she wish.

The Duty Governor also telephoned the man's mother at 5.30am after hearing that local police had visited her at her home to break the tragic news.

The man's family told my Family Liaison Officer and investigator that they felt that the prison had made it difficult for them to visit. They were originally told that they could not see the cell because the police had not released it yet. They felt that they only gained entry to the prison because they threatened to ring the local press to complain. The man's mother said she did not feel that the prison wanted to answer her questions and that they wanted the family "in and out".

I know the Governor of Brinsford was saddened to hear that the family had felt this way as he believed the prison had done all they could to be as helpful and considerate as possible during this difficult time. However, I believe it is only right that this reports reflects the families concerns and reminds us all of the importance of our responses at such crucial times.

The man's mother said she had been upset by the way her son's property had been returned to her. They did not receive the man's shoes for some months and only then after one of my investigators took up the matter for them. They were also confused about what the police had removed from the cell, and the prison did not seem to know either. The police had told her that a letter and a rosary had been left in a prominent place in the cell. They had never had the rosary returned to them.

The man's mother said that the alarm on the man's watch, which was returned to them, was set to go off at 8.18pm and the alarm was set to last for one minute.

Consideration, Recommendations and Good Practice

The PER form which accompanied the man from the Police Station to the Magistrates' Court offered no explanation as to why he was regarded as a risk because of drugs and self harm. I have repeatedly emphasised the importance of clear communication between agencies about the nature of risk and highlighted the difficulties this presents to Prison Service staff when making an accurate assessment of risk.

Although the man told staff during his first night assessment that he had been in Brinsford before, the ITSU staff were unable to access a computer with the capacity to search previous records. The computer on the ITSU is only used to allocate cells to new arrivals. The officer, who completed the man's first night risk assessment, agreed that the ability to look up prisoners on the computer would be helpful in providing extra information. He acknowledged he could have looked the man up the next morning and perhaps found his records under the name he had used for most of his life, if he had cross referenced his date of birth. Had he been able to do so, he would have seen that the man had been subject to self harm monitoring during 2002. This might have resulted in an F2052SH form being opened as a precaution.

> **I recommend that the Governor of Brinsford considers if a way can be found of building a search of LIDS which cross references a prisoner's date of birth into the assessment process. This would enable staff to satisfy themselves that they have all available information about a prisoner's previous custodial history.**

Generally, the initial assessment and induction process in Brinsford is of a much higher standard than in many other establishments. My investigators and I were impressed with the ITSU and the attitude of the staff who work there.

The man's initial assessment required him to be monitored for future indications of self harm and his state of mind. I am concerned that I have seen no evidence of how this was to be done. It is particularly regrettable that the man did not have the mental health assessment before he died.

> **I recommend that the Governor of Brinsford emphasises to staff the importance of timely mental health assessments if they are deemed necessary.**

I also note that the man was undergoing tests for epilepsy and that he had a fit a few days before being received into custody. I have seen no evidence of a plan for wing or healthcare staff to monitor him for further fits.

I am very concerned about the poverty of the regime in Brinsford and the perceived lack of interaction with wing staff. This was highlighted in HMCIP's report of 2005. It was also demonstrated by the fact that my investigators found that none of the wing staff they spoke to appeared to know who the

man was. It appeared to my investigators that only prisoners who presented control problems came to the attention of wing staff.

The long periods that prisoners are in their cells and the concomitant lack of interaction with wing staff must inevitably mitigate against proper monitoring of prisoners. I believe the amount of time the young men in Brinsford spend in their cell without any form of purposeful activity is unacceptable. I know the Governor is aware of the frustrations this causes and that the regime in Brinsford compares unfavourably with other establishments.

When I visited Brinsford, I found the cells to be bare and depressing. The cells are small, in need of decoration and have no cupboards, curtains or picture boards. It must have made a very unhappy sight for the man's family to see where he spent the last two weeks of his young life. There is also no Listener or Buddy scheme in operation.

I recommend the Area Manager and Governor review spending priorities for Brinsford in light of the findings of this report.

In terms of the prison's immediate response to the man's death, I note that the Nurse on scene said that she did not know what sort of emergency she was being asked to respond to when she received the emergency call.

I recommend that Brinsford adopt a code system similar to that in operation in other prisons so that all staff know what they will be required to deal with and can make sure they have appropriate equipment.

The scene attendance log was started at 10.35pm. I appreciate that only a skeleton staff are on duty at night, but this was comparatively late for a log to be started. Although good information was available on the communications room log and checklist, I note that Brinsford's own contingency plans provide that the Orderly Officer should instigate an attendance log as soon as possible.

Brinsford's death in custody contingency plans state that officers may enter a cell on their own when responding to an emergency, as long as they are satisfied that it is safe to do so. It appears that the OSG did take a decision to enter the cell alone. The contingency plans also require staff to commence resuscitation immediately. Neither the OSG nor the Night Orderly Officer did so in this case. While the nurse arrived very shortly after they entered the cell, and the evidence suggests that the man was dead by the time the alarm was raised, prompt action is vital in such situations. There is also evidence from the man's cellmate and the OSG that the Night Orderly Officer's first action was to pick the man up by his arm twice and let the body fall to the floor. I believe it would have been more appropriate for him to have begun CPR.

I am pleased that Brinsford's contingency plans put contacting the next of kin as the top priority. This is good practice. Too often, I have seen plans which

place this much further down the list. However, Brinsford still places reliance on the police to inform the family of a tragedy. I am pleased that the Duty Governor called the family as soon as he received confirmation from the police that they had been told, but I believe that responsibility for breaking the news is properly that of the Prison Service. In this case, the man's family heard the news some five to seven hours after he had died. If he had died during the day it is likely that a delay of this length would have resulted in the family hearing through unofficial means.

I recommend that the Governor of Brinsford places responsibility for contacting the next of kin with the Duty Governor or other senior member of staff as soon as possible after a fatal incident is discovered.

Good practice: Brinsford's contingency plans put contacting the next of kin as the top priority.

I am concerned that the sheet the man used was later used to cover the observation panel of a neighbouring cell.

I recommend that the Governor of Brinsford reminds staff of the importance of preserving evidence.

I am also concerned that the prison did not appear to know what the police had removed from the man's cell. This has caused the family great distress particularly as they say they found liaison with the police to be unsatisfactory.

I recommend that the Governor of Brinsford adds a requirement to the death in custody contingency plans that a specific member of staff be responsible for collecting a receipt of property form from the police for all items removed from the cell of the deceased.

I have seen no direct evidence that the man intended to commit suicide. His fellow prisoners believed him to be in good spirits and there is evidence that he was planning for the future. Only one prisoner believed him to be very upset about the letters he received from his mother and grandmother in the week before he died. His cellmate said that the man was "angry" and "gutted" but was not worried about him.

However, there is evidence that the man was suffering from some withdrawal symptoms. He complained to several other young men that he was "rattling" and was having problems sleeping. Other prisoners told my investigators that the withdrawal from subutex was worse than the withdrawal from drugs. I note that the man attended the Healthcare Centre on the morning of 12 February and did not complain of anything other than toothache. I draw attention to the conclusions of the clinical review and endorse the recommendation that the subutex regime should be adjusted to conform to the national guidelines that have been published since the man's death.

Despite the high incidence of young men withdrawing from drugs, there is no dedicated detoxification landing at Brinsford. Other prisons - for example, Low Newton - who also deal with a high number of drug dependent prisoners have a dedicated landing where prisoners are monitored throughout their detoxification programmes and given a high level of supervision and support. I believe Brinsford might well benefit from such a facility.

The Area Manager and Governor should consider whether Brinsford should have a dedicated detoxification landing or unit.

I note that the man's cellmate has given conflicting accounts of the circumstances in which he found the man and the actions he took. I draw no conclusions from this. The police found no evidence that the man had been assaulted in any way, and I am conscious that the stress of the situation could explain the inconsistencies in the cellmate's accounts. That said, the Coroner may well wish to call him as a witness at the inquest.