

**Investigation into the circumstances surrounding the
death of a man
at HMP Brixton in June 2006**

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

December 2007

This is the report of an investigation into the circumstances of the death of a man at HMP Brixton in June 2006. The man was found hanging in his cell in B wing. He was 29 years old.

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

The investigation was carried out by two of my colleagues. Lambeth Primary Care Trust agreed to carry out a review of the man's clinical care and treatment while at Brixton. At the time the final report was issued that review had still not been received and I made a recommendation about that. The clinical review was received a short while afterwards.

I would like to thank the Governor of Brixton, and his staff for their help and assistance during the investigation.

The man was unaccustomed to prison life and was described by one member of staff as both naïve and as a 'fish out of water'. However, after having some initial problems with other prisoners arising from his naïvety, the man seems to have settled when he was moved to B wing – probably Brixton's quietest wing. The man's main interest during association time was playing pool, but with only one other prisoner did he seem to form any real friendship. The man remained on remand throughout his seven months in prison custody but he said nothing to staff to suggest that he was growing frustrated by this. In contrast, he expressed his frustration when talking to his father by telephone.

Apart from the other prisoner with whom the man formed a friendship there was one officer with whom he spoke about current affairs. However, with neither did he speak about personal matters. The man's death came as a surprise to all who had contact with him.

I have made two recommendations relating to Brixton's contingency plans for dealing with a life threatening incident.

Stephen Shaw CBE
Prisons and Probation Ombudsman

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SUMMARY

On 13 June 2007, the man was found hanged in his shared cell at HMP Brixton. He was 29 years old.

At the time of his death, the man was a remand prisoner and had been in prison custody since November 2005. He was initially remanded into HMP Pentonville before being transferred to Brixton on 14 November. As part of the standard prison reception process the man was asked whether he had harmed himself in the past and whether he had any present thoughts of self-harm. The man answered no to both questions.

The man had a few problems on first arriving at Brixton – on two occasions he reported being assaulted by other prisoners and he was moved to a new wing each time. In response to one of these assaults, an F2052SH form¹ was opened to monitor the man in case he might be at risk of self harm. He said, however, that he had never harmed himself and the form was later closed.

On 3 December, the man was transferred to B wing where he appeared to settle. B wing is used mainly to hold Brixton's foreign national prisoners and also those who are vulnerable or who might be at risk from other prisoners. My investigators were told that B wing is a quiet and relaxed wing and that concurred with their own observations of the wing.

At a very early stage in the man's time in B wing one of the prisoners complained to the Principal Officer (PO) that the man had questioned the way in which he was observing his Muslim faith. When the PO spoke to the man about this, he replied that he was well read in various religions and enjoyed speaking with others about their faith. The PO told the man that it was not a good idea to do this in the prison environment, and the man acknowledged that it was this practice that had resulted in him being assaulted on the two previous occasions. The PO told my investigators that he thought the man was quite a naïve person and that, within the prison environment, he was a 'fish out of water'.

To a great extent this was the same opinion that my investigators gained from the one prisoner with whom the man seems to have had any sort of relationship. This prisoner said that the man would often come to his cell when they would play computer games and talk about music and the Bible. The man never spoke about personal matters, however.

Although the man seems not to have had any other proper friends, he spent a lot of time with many other prisoners as his main interest during association was playing pool. Two other prisoners said that they saw the man the evening before he died. Neither noticed anything about the man's behaviour that might have suggested that he was at any risk.

¹ At the time that the man was in Brixton the F2052SH form was used in the monitoring of prisoners judged to be at risk of self-harm or suicide. The F2052SH procedure has since been replaced with a different system – the ACCT (Assessment, Care in Custody and Teamwork) procedure.

In the same way that the man's relationships with other prisoners were largely superficial, this was also the case in his relationships with officers. He did not speak to any of the officers about personal matters, although he enjoyed talking about current affairs with one of the officers (the fourth Officer).

The man's records show that on a number of occasions staff had to speak to him about the cleanliness of his cell and about his personal hygiene. The fourth Officer told my investigators that it was covered in his initial officer training that a deterioration in a prisoner's hygiene can be indicative of the onset of depression and a warning sign that the prisoner might be at risk. However, with the man this merely seems to have been part of his personality. All officers agreed that once reminded, the man would shower and clean his cell and was never offended when spoken to about this.

On 11 and 12 June 2006, the man spoke with his father a number of times asking his father to apply for bail on his behalf. My investigators listened to a tape recording of these telephone conversations. They noted that the man was clearly angry and frustrated when his father tried to explain that obtaining bail would not be straightforward.

The man did not mention to any of the officers that he was growing frustrated with the length of time he had remained on remand. Nor did the officers notice anything about the man to cause them to feel any concern for his safety.

During the last week of the man's life his cellmate was a Tamil national. The cellmate told my investigators that he and the man did not speak for the first five days that they shared a cell, but that they began speaking in the final two days. At 3.00am on 13 June, the cellmate woke as he needed to use the toilet. When he got out of bed he saw the man hanging from a ligature tied to the window frame. The cellmate rang the cell call bell and staff responded. Descriptions of the man's body when found suggest that he had already by then been dead for some time. Even so, staff attempted to resuscitate him but without success.

THE INVESTIGATION PROCESS

The investigation was opened on 15 June 2006 when two of my colleagues visited Brixton and met a number of prison staff. These included the governing Governor, the prison's family liaison officer and a representative from the Prison Officers' Association. My colleagues also met a representative from the Independent Monitoring Board (IMB). My colleagues informed the staff of the nature and scope of the investigation. Notices were issued to staff and prisoners notifying them of my inquiry. Nine members of staff and seven prisoners were interviewed. Five of these prisoners came forward in response to the published notices.

Lambeth Primary Care Trust agreed to carry out a review of the man's clinical care and treatment while at Brixton.

One of my Family Liaison Officers contacted the man's father to inform him of the investigation and to ask if there were any particular issues that he wished to raise. When the draft report was issued to him, the man's father questioned why Brixton seemed not to have explored his son's mental health history.

HMP BRIXTON

Brixton first opened in 1819 and in its time has been both a prison for women and a military prison. Brixton's primary role now is as a local prison holding remand and trial prisoners committed to the local magistrate's courts as well as the Inner London and Southwark Crown Courts.

Brixton comprises four main residential units. B wing, where the man was located, was used primarily as Brixton's foreign prisoners unit.

The last inspection of Brixton by Her Majesty's Chief Inspector of Prisons, Ms Anne Owers, was an unannounced inspection in February and March 2006. Ms Owers's findings included:

"The inspection found continuing improvement [since the previous inspection] in some areas. Prisoners were out of their cells a great deal, for longer periods than we have seen in most public sector local prisons ...

"In spite of the obvious enthusiasm of senior managers, the improvements that have been put in place, and the commitment of many staff, Brixton was still not performing sufficiently well against three of our four tests of a healthy prison – respect, purposeful activity and resettlement ... Managers have ensured that Brixton has developed a sense of purpose and a positive vision of what can be delivered. However, in order for that vision to be realised, it needs capital resources from the centre ..."

KEY EVENTS

The lead up to the man's death

On 3 November 2005, the man was arrested and taken into police custody. On 4 November, the man was taken to Thames Magistrates' Court where he was charged with grievous bodily harm and remanded into prison custody. This was the first time that the man had been in prison.

The man was taken to HMP Pentonville and upon arrival there received a first reception health screen (this is a standard part of the prison reception process). Among other questions, the man was asked whether he had ever received psychiatric treatment or medication for mental health problems and he replied that he had not. He was asked whether he had ever tried to harm himself and he again replied that he had not. The man also answered no to a question about whether he had any current thoughts of self-harm. The man had no problems to report in connection with his physical health and he said that he did not think there was any reason for him to see a doctor.

On 14 November, the man attended Southwark County Court for a preliminary hearing. The case was adjourned to a later date and the man was remanded into HMP Brixton. At Brixton, the man went through an abbreviated version of the first reception health screen that is used when a person transfers from one prison to another. The man again reported having no problems with his physical or mental health.

On 21 November, the man complained to staff that he was being bullied in A wing so he was transferred to G wing. As a direct result of the assault, an F2052SH form was opened on 30 November in case the man might be at risk of self-harm. However, even on the day the F2052SH was opened, the man said that he had never self-harmed and he refused an assessment by Brixton's psychology outreach team.

On 27 November, the man was seen by one of the prison GPs. The GP recorded that the man's past medical history included manic psychosis. The GP referred the man to the psychiatric outreach team.

On 3 December, the man was assaulted in the gym suffering cuts and bruises to his head and face. He said that he had been attacked by five or six black and Asian prisoners and he was moved to B wing. The PO told the investigators that he had been the wing manager for B wing at Brixton since around April 2005. He said that B wing is primarily used to house Brixton's foreign nationals as well as prisoners on Prison Service Rule 45 for protection and safety (that is, prisoners at risk of attack by other prisoners). The PO said that in general the foreign national population at Brixton are very well behaved so B wing usually enjoys a relaxed atmosphere.

The PO said that he had cause to speak with the man shortly after he arrived in B wing when one of the Muslim prisoners complained that the man told him that he was a 'bad Muslim'. The PO said that the man told him that he was well read on different religions and he had simply told the other prisoner that, if a person smoked,

they cannot be a good Muslim. The man added that it was a similar situation that led to him being assaulted in G wing. The PO said that he explained to the man that in a prison environment it was best to keep one's opinions to oneself. The man seemed to understand this and the problem fizzled out quite quickly. In talking with the investigators, the PO said he did not think that the man made these remarks to upset people. Instead, it was simply that he was the type of person who would invite dialogue on a subject and expect others to explain their views. The PO said that, although the man appeared well read, he also seemed rather naïve in terms of understanding people and understanding the situation he was in. He described the man in prison as a 'fish out of water'. Even so, the PO thought that the man got along with most of the prisoners in B wing, although he tended to stick mainly with a small group of friends. The PO remembered the man seeming quite confident at one stage that his father and solicitor would be able to arrange bail. As time went on, the man did not raise that matter again but nothing came to the PO's attention to indicate that the man was becoming frustrated with the length of time he had remained on remand.

The PO told my investigators that he had seen the man for the purpose of F2052SH reviews. He had never had any real concern about him as he seemed quite outgoing and not a person who appeared at risk of suicide or self-harm.

On 16 December, a doctor from the psychiatric outreach team visited the man in B wing. The psychiatric doctor recorded that the man refused to engage with him. The psychiatric doctor spoke to staff about the man and then spoke to Brixton's consultant psychiatrist. The psychiatric doctor made an entry in the man's records: *'Discussed [with the consultant psychiatrist]; close case as no indication of mental illness currently.'*

On 16 January 2006, the man was seen by a member of Brixton's psychology team for an F2052SH review. She noted the man telling her that he had never harmed himself, had never been depressed and that the opening of the F2052SH had been a misunderstanding. The psychology team member recorded telling the man that if he were to feel low in the future he should tell staff about this. The F2052SH was closed that day.

On 30 April, an entry was made in the man's records that staff spoke to him about his personal hygiene as he had stopped taking showers. The entry went on to say that the man had refused to do anything about the problem. Ninety minutes later a further entry was made to say that the man had reconsidered and taken a shower.

On 19 May, the man was taken to court for a remand hearing. Due to overcrowding at Brixton, by the afternoon of that day the man was transferred to HMP Chelmsford. He was transferred back to Brixton on 26 May.

The first Officer told the investigators that she had been in the Prison Service for nine months and she mainly worked in B wing. She said that the man settled in well after arriving in B wing upon his transfer from G wing. Although the man was subject to special (F2052SH) monitoring when he first came to B wing, the first Officer did not think that he seemed at risk. The first Officer had asked him how he was at this time and he had replied that he was not suicidal, just a little bit down. On a

subsequent occasion, the first Officer spoke with the man about his personal hygiene and the cleanliness of his cell. She asked him if he was doing this as a form of protest. The man replied that he had maids at home so cleaning was not something that he did. The first Officer said that, when staff spoke to the man about these issues, he took it well and would clean himself and his cell.

The first Officer said that although the man was a quiet person, he mixed well with other prisoners and spent most of his day playing pool. He did not have a large group of friends, but there was a group with whom he socialised including one other prisoner in particular. The first Officer said she spoke to the man on the evening before he died. He was sitting in his cell smoking. She asked him how he was and he replied that he was fine. She said she was shocked when she heard that the man had hung himself. Nothing had occurred to give the first Officer any cause to feel concern for the man's safety, nor did he ever say anything to her to indicate that he was frustrated about the length of time he had been waiting for his case to come to trial.

The second Officer told my investigators that he had worked at Brixton for 17 years. He said that he did not have a great deal of contact with the man, but from the contact they did have, he thought the man seemed quite happy. The man never came to him with any concerns or complaints. The second Officer did not think that the man established a relationship with anyone apart from with one other prisoner. At the same time, the man had no problems going out on association when he would usually play pool. The second Officer said he was on a rest day when he read about the man's death on teletext. He said he was amazed to read this news. He added that all of the officers were surprised.

The third Officer told my investigators that he had worked in the Prison Service for 18 months. Throughout that time he had always worked in B wing at Brixton. He gave similar evidence to other staff about the man's behaviour and how he fitted in to the wing: that he needed to be reminded to keep his cell clean, that he played pool most of the time, that he formed few meaningful relationships, that he was well behaved, most of all, that nothing occurred to suggest that he might have been at risk of suicide or self-harm.

The fourth Officer told my investigators that he was still in his first year as a new officer. He had spent about seven months working in B wing before transferring to the segregation unit around two months before the man's death. The fourth Officer recalled that he and other officers had wondered why the man was on an open F2052SH form when he arrived in B wing as there was nothing about his behaviour to give staff cause for concern. He was also engaging in normal wing activities although the only activity he was really interested in was playing pool. The fourth Officer said that during his initial training it was pointed out that a possible warning sign of a person being at risk of self-harm is a deterioration in their personal hygiene. He said, however, that in the man's case the standard of his hygiene remained fairly constant. The fourth Officer said that every now and then officers would tell the man to clean himself and his cell and, when told, he would do so.

The fourth Officer said that after his move to the segregation unit he would still bump into the man when walking through B wing. He said the man would always approach

him to talk about current affairs. In particular, he was interested in the investigations and conspiracy theories surrounding events such as the attack on the World Trade Center in New York and the London bombings. The fourth Officer said the last significant conversation that he and the man had was around two or three weeks before the man's death. The man asked for advice about some property that the police had confiscated. The fourth Officer said that at no time did the man seem to be getting frustrated with the length of time he remained on remand. The fourth Officer was on leave when he discovered that the man had taken his life. He said that this news had stunned him.

The fifth Officer told my investigators that he had joined the Prison Service five months earlier and that he worked on the 2's landing in B wing. The fifth Officer said that the man enjoyed playing pool and never had any problems with other prisoners. Whenever the fifth Officer asked the man if he was all right he always answered that he was fine. The fifth Officer said he had experience of opening F2052SH forms when he had judged prisoners to be at risk of self-harm, but he never had any reason to feel that the man was at risk.

A prisoner (the man's friend) was identified by several staff as the one prisoner with whom the man had a close relationship. The man's friend told my investigators that the man would come to his cell and they would play computer games. They would also talk about music and the Bible. He described the man as immature and a loner. The man never spoke about personal matters and nor did he talk about his case. He said the man stopped coming to his cell in the final weeks of his life. He did not ask the man why he had stopped coming but he knew that the man continued playing pool with other prisoners.

My investigators spoke with two other prisoners who had some contact with the man. One said that the man's main interest was playing pool, although he was also interested in music. He thought that the man was worried about his court case although he did not know why. He said that he last saw the man the evening before he died when he seemed his usual self. He also said he did not understand why the man did what he did. The other prisoner also said that he was with the man the evening before he died. The man was chatting and joking and laughing.

The man had a new cellmate in the last week of his life. The cellmate said that he and the man did not speak for the first five days but they exchanged a few comments in the final two days. The man asked the cellmate why he was in prison and the cellmate told him why. The man said that he was due to go to court on 13 June for a bail hearing, but did not say what his case was about.

The man's father attended court on 12 June on his son's behalf. The man spoke with his father by telephone on five occasions during 11 and 12 June. He wanted his father to put in a bail application on his behalf. My investigators listened to a recording of these conversations. The man's father tried to explain to his son that the process would not be so straightforward. In all of the calls there was much disagreement and argument.

The discovery of the man's death

The cellmate said that he fell asleep at about 11.30pm on 12 June. He woke at about 3am on 13 June because he needed to use the toilet. When he got out of bed, the cellmate saw the man hanging from a ligature tied to the window bars and he rang the cell bell.

The fifth Officer was on duty in B-wing with the OSG². He said that at about 3.00am he responded to a call bell from a cell on the 2's landing. When he looked through the observation flap he saw the cellmate sitting on the top bunk pointing to the window. The fifth Officer saw the man hanging from a ligature tied to the window bars. The fifth Officer said that, as there were two prisoners in the cell, he decided that he would not take the risk of entering the cell alone. Instead, he ran back down to the landing below and telephoned the Orderly Officer³ to tell him what had happened. The fifth Officer then returned to the cell with the OSG. They went into the cell and the fifth Officer cut the ligature with his anti-ligature knife. The fifth Officer said that, after laying him onto the cell floor, he started trying to resuscitate the man with mouth to mouth breathing and chest compressions. Within about two minutes, healthcare staff arrived and they took over the efforts of trying to resuscitate the man.

The OSG said that the fifth Officer went to answer a cell bell and then ran back to say that one of the prisoners was hanging. Between them they used the telephone and radio to contact the appropriate people, including the control room and the medical team to say a Code 1 incident was occurring.⁴ The OSG said they then ran to the cell and the fifth Officer used his anti-ligature knife to cut the man down. The OSG said the man's body was cold and was beginning to go stiff. The two Orderly Officers arrived and with the fifth Officer they pulled the man onto the landing where they would have more room. The OSG said that healthcare staff arrived at about this point; she estimated that it had taken them less than a minute to arrive. The OSG said she is not first aid trained and so did not help with the efforts to try to resuscitate the man.

The Orderly Officer said he was with the Assistant Orderly Officer when the fifth Officer telephoned to say that a prisoner was hanging so they ran to B wing. The Orderly Officer said they arrived in the man's cell just as the fifth Officer was cutting the ligature. The Orderly Officer confirmed that the fifth Officer was the only staff member involved in trying to resuscitate the man before the arrival of healthcare staff.

In a written statement, the Nurse wrote that she was called by radio to attend B wing. On arrival she commenced efforts to try to resuscitate the man and continued until the arrival of ambulance paramedics. The Nurse described the man's body as cold

² Operational Support Grade (OSG) staff are one grade below Prison Officer grade. OSGs carry out tasks that do not involve a great deal of prisoner contact.

³ The Orderly Officer is the officer in charge of a prison at night and is designated Oscar 1.

⁴ A Code 1 incident signifies a life threatening incident.

and cyanosed (cyanosis is the condition when bodily extremities turn blue through lack of oxygen). The Nurse ended her statement by noting that the man was pronounced dead at 3.43am.

A handwritten log of events completed by the Assistant Orderly Officer records that at 3.01am he was told by the Orderly Officer that they had to go to B wing. He recorded that they arrived at the man's cell at 3.03am and the Nurse arrived at 3.05am. The communications room were asked to call an ambulance at 3.10am. The Assistant Orderly Officer did not record the arrival of ambulance paramedics but their arrival was elsewhere recorded at 3.20am.

The communications room log shows that the call to the ambulance service was made at 3.13am.

AFTER THE MAN'S DEATH

Brixton contacted the police local to the home of the man's father, and asked them to visit to break the news in person of his son's death. Later that day, Brixton's governing Governor together with a family liaison officer (FLO) visited the man's father. His brother and another male relative were with him. The governing Governor offered his condolences and explained the procedures that follow upon deaths in prison custody. An offer was made to the man's father for him to visit his son's cell and he took up that opportunity. Brixton paid for the funeral expenses.

Both staff and prisoners received an appropriate level of care and support from the prison.

BRIXTON'S CONTINGENCY PLANS

Brixton's contingency plans dated 13 October 2003 for dealing with the attempted suicide, serious injury or apparent death of a prisoner include the following instructions:

'When a call is received into the Communications Room the officer in charge will:

'1. Inform Hotel 6⁵ ... that urgent medical assistance is required ...

'2. Contact the Ambulance Service, by telephoning 999, requesting an urgent response i.e. "Blue Light".

...

'Notes

'The ambulance is to be called as instructed above in every case. If the injury turns out to be minor, or the prisoner is confirmed dead by a doctor, the Ambulance Service can be informed to scale down or cancel the call. The Communications Officer must not wait for details from the scene before calling the ambulance.'

Brixton's guidance notes for staff dated 6 July 2006 reiterate that communications/control room staff should ring 999 to request an ambulance when they are notified that a Code 1, life threatening, incident has occurred.

Brixton's guidance notes for staff first on scene, also dated 6 July 2006, state that where a prisoner is found hanging and is not breathing, resuscitation should be attempted.

Prison Service Order (PSO) 2700 provides national guidance on dealing with deaths in prison custody. It instructs that in the case of a prisoner found hanging and not breathing, resuscitation should be attempted unless rigor mortis of the limbs has clearly set in.

⁵ Hotel 6 is the radio call sign of the primary healthcare responder.

FINDINGS AND CONCLUSIONS

The man was arrested on 3 November 2005 and, after spending the night in police custody, was remanded into HMP Pentonville. On arrival in Pentonville on 4 November, the man had a first reception health screening interview during which he denied any past or present acts or thoughts of self-harm. The man remained in Pentonville until 14 November when he was taken to court and from there was remanded into Brixton. During an abbreviated inter-prison transfer reception screen the man again denied any history of self-harm.

In his first few weeks in Brixton, the man was assaulted on more than one occasion by other prisoners. This led to him being moved to different wings in the prison. On 3 December, the man was moved to B wing where it seems he was able to settle.

B wing is primarily used to hold Brixton's foreign national prisoners, although it also holds certain other categories of prisoner, such as those deemed at risk from others. The Principal Officer (PO) said that B wing is quite a relaxed wing. I understand from my investigators that that was their impression on visiting the wing. The PO said he believed that the reason the man was assaulted by other prisoners was because he had questioned their observance of their Muslim faith. The man did precisely the same thing shortly after arriving in B wing, causing a prisoner to complain about him. The PO said he spoke to the man about what had happened. The man's explanation was that he was well read in different religions. He said he had merely pointed out to other prisoners that habits such as smoking should not be practised by followers of certain faiths. The PO said he told the man that prison is not an appropriate environment to engage in such discussions. The PO did not think that the man had deliberately attempted to antagonise the other prisoners. He just thought that the man was quite a naïve person.

At the time of the man's arrival in B wing, he was being monitored through the F2052SH process as he had been judged to be at risk of self-harm. The reason this monitoring started was directly because of the assaults he had suffered. However, the man was adamant that he had never committed acts of self-harm, had never been depressed and that the opening of the F2052SH form had been a mistake. The F2052SH was closed on 16 January 2006.

The fourth Officer said at interview that the man was engaging in normal activities and nothing occurred to give staff cause for concern. Out of all the staff in B wing, the fourth Officer seems to have been the one with whom the man formed his closest relationship. The fourth Officer told my investigators that the man enjoyed talking with him about current affairs. The fourth Officer said that, even after he had transferred to a different unit, the man always spoke with him each time he went to B wing.

The fourth Officer apart, the man seems only to have had superficial relationships with other staff. Certainly none reported the man confiding in them about personal matters. Nor, in fact, did the man talk of personal matters with the fourth Officer. The only slightly personal matter they discussed was when the man asked the fourth Officer for his advice about dealing with a problem connected with property that the police had confiscated.

The man's relationships with other prisoners were also superficial. His main contact with other prisoners was through engaging in his favourite activity of playing pool. The arrangement with games of pool is that the winner remains on the table and the effect of this is that the man would have played against a variety of partners. It is clear, therefore, that he was comfortable being around other prisoners, even though he did not seek to forge deeper relationships with them. The one prisoner with whom the man did spend some time, the man's friend, said the man would come to his cell to play computer games. They also spoke about music and about the Bible. The man did not speak about personal matters however.

The man spoke with his father a number of times on 11 and 12 June to discuss a bail application he wanted his father to make on his behalf at court on 12 June. These conversations were recorded and they display great misunderstanding between the man and his father about what the bail process entails. By this time the man had been on remand in prison custody for seven months and both anger and frustration were very apparent in the man's voice as he spoke with his father. In a statement to the police, the man's father acknowledged that he and his son had a volatile relationship.

Although the man's telephone conversations with his father on 11 and 12 June indicated frustration, it does not appear that he said anything to staff about the length of time he had remained on remand. Indeed I have found no evidence to indicate any noticeable change in his behaviour in the final weeks, days or hours of his life. As a result, none of the staff anticipated that the man was at risk as indeed there was no reason that they should have done.

The man's cellmate in the final week said that he and the man did not speak for the first five days but they exchanged a few comments in the final two days. The cellmate woke up at about 3.00am on 13 June and saw the man hanging from a ligature tied to the cell window. He pressed the cell bell.

The fifth Officer was on duty in the wing with the OSG. When he looked through the cell door observation panel the cellmate pointed to the man. Because the cell was occupied by two prisoners, the fifth Officer judged that it would not be safe to enter the cell alone. This was a matter upon which he was entitled to apply his own judgement and I would not criticise him for his decision.

The fifth Officer ran to the landing below where he raised the alarm by telephoning the Orderly Officer. The control room was also alerted. The fifth Officer and the OSG then ran to the cell, unlocked the door, entered and cut the ligature. The fifth Officer commenced attempts to try to resuscitate the man and continued until he was relieved upon the arrival of healthcare staff. The Nurse arrived and she continued with the efforts to try to resuscitate the man until the arrival of the ambulance crew. The Nurse described the man's body as cold with the presence of cyanosis. It would seem therefore that the man was already dead at the time he was first discovered hanging. He was officially pronounced dead at 3.43am.

Although it almost certainly had no affect on the outcome, there was a slight delay in an ambulance being summoned. The control room was notified at about 3.01am.

The Nurse was informed straight away and according to Brixton's contingency plans the control room staff should next have telephoned 999 to call an emergency ambulance. Instead, the ambulance was not summoned until 3.13am. I do not know the reason for that delay.

When the man's father was sent the draft version of this report he questioned why Brixton seemed not to have explored his son's mental health history. The man's psychiatric care and treatment is to be considered in the clinical review to be carried out by Lambeth Primary Care Trust.

RECOMMENDATIONS FOR BRIXTON

1. The Governor should remind control room staff that in the case of a Code 1 incident, an emergency ambulance should be summoned without delay.
2. The Governor should consider revising Brixton's contingency plans for dealing with deaths in custody to bring them more closely in line with national guidance: specifically, that resuscitation need not be attempted when rigor mortis has set in.