Investigation into the circumstances surrounding the death of a man at hospital in May 2011 whilst in the custody of HMP Brixton

Report by the Prisons and Probation Ombudsman for England and Wales

March 2012

This is the report into the death of a man in May 2011 at hospital whilst in the custody of HMP Brixton. He was 44 years old. Although the cause of death is unconfirmed at the time of issuing the draft report, it is probable that he died from an acute sudden bilateral cerebellar infarction (or stroke). We offer our condolences to his family and friends for their loss.

The Senior Family Liaison Officer contacted the man's family to inform them about the investigation and to provide them an opportunity to raise any issues about the care he received in custody.

The investigation was carried out by an investigator. We thank the Governor of HMP Brixton and his staff for their co-operation during the course of our enquiries.

The local Primary Care Trust (PCT) appointed a clinical reviewer to review the man's clinical care on their behalf. The review concludes that the standard of care he received was equitable to that which he could have expected in the community.

We make three recommendations, which address staff support and record keeping.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons & Probation Ombudsman **March 2012**

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SUMMARY

1. The man was arrested on 15 April 2011 and appeared at Magistrates' Court on 16 April. He was remanded into custody and sent to HMP Brixton. On arrival, he underwent a first reception health screen with a nurse where he disclosed that he had been receiving treatment for a urinary tract infection and was concerned that he had problems with his prostate. He was seen by a prison doctor the same day and prescribed medication to treat his infection. No other medical issues were discussed. He told medical staff that he was a smoker, but had no wish to stop.

2. The man was compliant with the prison regime and was in a single cell. According to staff and prisoners, he appeared to have maintained a low profile, generally choosing not to socialise with other prisoners.

3. On 18 April, the man called for healthcare assistance because he felt unwell, experiencing a headache and palpitations. The nurse who responded assessed him as experiencing a panic attack. On 4 May, he was prescribed a sedative anti-histamine, after telling staff that he still felt anxious and couldn't sleep. There were no further recorded interactions over the next few weeks.

4. The man called for assistance on 22 May, when he was experiencing breathing problems. The nurse who examined him diagnosed a further panic attack and referred him to the prison doctor, who examined him the following day. During this consultation he told the doctor that he was anxious as he thought he had prostate cancer and was given reassurance that his condition would be reviewed.

5. During the lunchtime period on 24 May, the man used his cell bell to alert staff that he felt unwell. Following examination by healthcare staff an emergency ambulance was requested and he was taken to hospital. Over the next few days he underwent several tests, but his condition quickly deteriorated. His family were advised that his condition was not treatable and he died soon after.

6. A prison family liaison officer was appointed prior to the man's death. He was able to give the family information at hospital and organised a visit to the establishment. He also returned the man's property to his family. The prison offered financial assistance towards the cost of the funeral.

7. We are satisfied that the care the man received at Brixton was comparable to that which could be expected in the community. We make three recommendations which address staff support and record keeping.

THE INVESTIGATION PROCESS

8. The investigation was opened on 2 June 2011, when the investigator visited the establishment and met the Governor. She issued notices announcing the investigation to staff and prisoners and met the prison liaison officer for the investigation, and reviewed the man's records. She visited cell B1-01 on B wing where he lived, and spoke informally with some prisoners on this wing.

9. The investigator also met the B wing manager, the Chair of the Independent Monitoring Board (IMB), the Head of Healthcare and the prison family liaison officer. No prisoners came forward in response to the notices of my investigation, but a volunteer worker from the chaplaincy department telephoned the investigator to advise her that she had known the man.

10. My investigator returned to Brixton on 16 June. During this visit, she formally interviewed three members of staff and spoke to two officers from B wing. She returned to Brixton on 21 June and 2 August where, together with the clinical reviewer, they interviewed three additional members of staff and had a second interview with the prison doctor. Initial feedback was sent in writing to the Governor on 9 August.

11. The local Primary Care Trust (PCT) asked a clinical reviewer to review the man's clinical care on their behalf and he was provided with all relevant documentation to assist this review. We thank him for undertaking this review and for his timely report.

12. The investigator contacted Her Majesty's Coroner responsible for the Inner South London District area to inform him of the nature and scope of the investigation and request a copy of the post mortem report. Upon completion, the investigation report will be sent to the Coroner to assist his enquiries into the man's death.

13. The senior family liaison officer (FLO) contacted the man's cousin by letter on 5 July, to inform her about the investigation and to invite the family to ask questions or raise concerns about his care. The family did not raise any issues. As part of the consultation process, the family received a copy of the draft report. Initially, an extension was requested and agreed while they considered there feedback. However, on 5 March the solicitor representing the family informed the PPO that they did not wish to make any comment on the report.

HMP Brixton

14. HMP Brixton is a large Victorian prison, which now occupies a very cramped site. It is a male local prison (a prison that sends and receives prisoners directly to and from the courts. These prisons experience large numbers of movements through the reception each day and are extremely busy) serving a number of courts in South London. The prison now has an operational capacity of 798, with a very high turnover, of about 700 prisoners a month.

15. Healthcare services are delivered by a group led by Care UK, including the South London and Maudsley NHS Foundation Trust (SLaM), with pharmacy and other services provided by Lambeth Community Health, and dental services by Weymouth Group. NHS Lambeth (the Primary Care Trust) is the commissioner and holds the contract with Care UK, which was recently extended to 2013

Independent Monitoring Board (IMB)

16. Each prison has an IMB, whose members are independent volunteers from the community. Their role is to satisfy themselves that the prisoners are treated humanely and justly. The IMB submit annual reports on how the prison has met the standards and requirements placed on it. Members of the IMB have access to every prisoner, every part of the prison and every prison record. The man had no contact with the IMB.

17. The most recent annual report published by the IMB at Brixton covers the period from 1 July 2009 to 31 August 2010, in the overall judgement of the establishment, the Chair reports:

> "The Board's overall judgement is that Brixton is continuing to improve at a steady pace. This was recognised when its performance status was raised from 2 to 3. This is judged by national targets, so it is a real achievement within Brixton's constraints."

HM Inspectorate of Prisons' report

18. An unannounced full follow up inspection of HMP Brixton by HM Chief Inspector of Prisons was completed in December 2010. In his introduction to the report of the inspection, the Chief Inspector said:

> "Brixton had improved since our last inspection. Some of these improvements were significant. However, the problems that did remain were substantial and it was clear that managers and staff would struggle to maintain what, in many respects, were the minimum of basic standards"

19. In respect to healthcare services, the Chief Inspector said:

> "Health services were well managed by the various providers, and the environment in the health care centre for the care and treatment of

patients was adequate... Prisoners received a good level of GP care and waiting lists were short. Facilities for the administration of medicines were satisfactory."

Previous deaths at HMP Brixton

20. There have been three previous deaths at Brixton in the past year. The investigator reviewed the Ombudsman's reports into these deaths and she found no issues in common between the earlier deaths and that of the man. There have been seventeen previous deaths in total since the Ombudsman was given responsibility for investigating deaths in custody in England and Wales in April 2004, six due to natural causes, nine self-inflicted, one due to an illicit drugs overdose and one unclassified. There are no similarities between these previous deaths and that of the man. However, during the course of our enquiries in an investigation at a different prison, we had cause to criticise Brixton (from where the prisoner had been transferred), for not providing access to all the necessary documentation to our investigation. Those concerns are repeated in this investigation.

Person Escort Record (PER)

21. This is a form that accompanies prisoners on all journeys from and between prisons. It serves as a communication tool about risks a prisoner poses on escort or transfer. It also provides a chronological record of the escort, for example when meals are served or times journeys are started.

Cell Sharing Risk Assessment (CSRA)

22. All prisoners are subject to a Cell Sharing Risk Assessment (CSRA) on reception. The CSRA process is designed to assess the risks posed by an individual to other prisoners which includes taking into account any previous violence or mental health issues. An assessment takes place before a prisoner spends their first night in custody and triggers a plan to minimise risk for those identified as high or medium risk which is reviewed at regular intervals. The CSRA form for the man could not be located and was not available to the investigator.

Restraint Risk Assessments

23. On each occasion a prisoner is escorted outside the prison to hospital, a risk assessment is undertaken to consider the risk to the public, potential for escape and likelihood of outside assistance. The assessment informs the decision about the number of escorting officers and the type of restraint to be used (single cuffs or two metre long escort chain with a cuff at either end). It also determines the circumstances and the authority required for the restraints to be removed. The risk assessment is reviewed each day that a prisoner is in hospital and amended where necessary.

Induction

24. Induction is the process of introducing new prisoners or newly sentenced prisoners into custody. It is designed to:

    - explain the immediate consequences of being in custody
    - explain the routines of the prison
    - explain the rules and regulations they must observe
    - explain the procedures governing certain processes, such as obtaining visits
    - offer practical advice on obtaining goods and services; and
    - help prisoners understand how to navigate their way around issues of imprisonment.

25. Staff should check that prisoners understand what is going to happen to them and attempt to deal with any immediate problems. PSO 0550 and PSI 27/2006 provide further guidance. The induction documents for the man could not be located and were not available to the investigator. This is commented on later in the report.

KEY EVENTS

26. The man was born in August 1966. Prior to his reception at HMP Brixton he lived in the Stoke Newington area of London with his partner and her son. He was arrested on 15 April 2011, for an alleged offence of robbery. He appeared at Magistrates' Court on 16 April when he was committed for trial at Crown Court, remanded in custody and taken to Brixton. A Person Escort Record (PER) had been completed, which indicated that he may pose a risk to others, based on the circumstances of a significant previous conviction, for which he served a prison sentence.

27. A nurse completed an initial health screening with the man as part of the reception process. His weight was 72kg, but his blood pressure was not recorded. He told the nurse that he was a smoker, with no desire to stop and that he did not have any substance misuse issues. He disclosed that he had recently visited his GP as he had problems with his prostate (the prostate is part of the urinary tract and male reproductive organs) and had been prescribed ciprofloxacin (an antibiotic used for treating infections of the urinary tract). He did not disclose any history of mental health problems or other medical issues.

28. Later the same day, the man was examined by a prison doctor. She diagnosed prostatitis (an infection of the prostate gland) and continued his prescription of ciprofloxacin. He was also given a routine appointment for sexual health screening on 3 May, although he subsequently failed to attend.

29. A Cell Sharing Risk Assessment (CSRA) is also completed during the reception process. This document is used to determine the appropriateness of placing prisoners in shared cells, and if there are any known risks or concerns. The man's CSRA was not provided to the investigator, although staff interviewed recalled that he was assessed as high risk, due to a previous offence and that it was not appropriate for him to share a cell. Initially, he was located on C wing, the induction wing. During this period it is normal for prisoners to receive information about the prison's rules and regime and what to expect. However, the prison was not able to locate and provide the investigator with the induction documents for him to confirm that he had completed the programme. This issue is further considered in the issues section of the report.

30. On 18 April, the man used his cell bell at approximately 11.00pm to alert staff that he was feeling unwell, saying that he had a headache, palpitations and that he felt stressed. The investigator requested a copy of the cell bell log to determine how quickly this cell bell was answered, but was told by Brixton that due to a technical problem, the information was unavailable.

31. A nurse attended. She recorded the man's blood pressure as 126/75 (the normal range for blood pressure is 100/70 to 140/90, although the pressure varies throughout the day depending on the individual's activities. A blood pressure reading of greater than 140/90 is classed as high and a reading of 90/60 or below is classed as low), pulse as 72 and that it was regular (normal

range is between 60 – 80 beats per minute – bpm). He was prescribed paracetamol and told to submit an application the next day if he was still feeling unwell and he would be referred to primary care mental health team (PCMHT). She recorded in the electronic medical file 'reporting headache and palpitations, thinks he [the man] is a bit stressed'. She also told wing staff, if the CSRA did not state otherwise, that he should be located in a shared cell.

32. During interview, the nurse told the investigator that she thought the man may benefit from sharing a cell, as he had told her that the process of writing letters to his family helped alleviate his stress levels and that in her opinion sharing a cell may be of benefit to him. She went on to say:

> "… he reported just a mild headache …he was relating it to a headache he had once a couple of years ago that when I [the man] was stressed I had this kind of palpitation, and I know it's because I'm stressed".

33. The nurse did not see the CSRA form and told my investigator that she would rely on the wing officer to make any arrangements. A SO confirmed during interview that the man remained in a single cell as he was assessed as posing a high risk to others, although he too had no specific recollection of seeing his CSRA form.

34. Once prisoners have completed the induction programme, they are moved from the induction wing to a general residential wing. Although it is not possible to confirm whether he completed the induction programme, the man was moved from the induction wing to B wing on 19 April.

35. On 4 May, a prison doctor prescribed promethazine hydrochloride (a medication for insomnia), as the man had reported to nursing staff that he was anxious, stressed and could not sleep. During interview the doctor said:

> "…if someone is in prison I normally give that sometimes when someone is worried or they're not getting sleep, you know just to calm them down. Sometimes that is helping… from my knowledge this medicine is an anti-histamine, so it's not a medicine that I need to check the blood pressure or examine the patient"

36. Five days later, the man was examined by another prison doctor, due to the ongoing problem with his prostate. The doctor diagnosed benign prostatic hyperplasia (a non-cancerous enlargement of the prostate), and requested that his prostate specific antigen (PSA - a test to determine the presence of prostate cancer) is checked, with a view to a possible referral to a urology clinic (specialists in urinary tract diseases and men's sexual health). The test results were received on 10 May, and were within normal limits.

37. A nurse went to the man's cell on 22 May at 5.25pm as he was complaining of breathing problems. The nurse recorded that he "appears anxious sweating, restless, hyperventilating complaining of tingling sensation in both arms as

well as headache". The nurse gave some reassurance to him, gave him some cold water to cool down and ibuprofen (for pain relief). His blood pressure was recorded as 121/51, pulse 75 and blood sugar 4.6 (normal range is between 3.5 – 5.5 before meals, and less than 8 within two hours after meals). He had good capillary refill (a test to assess the blood circulation in an individual), with no other symptoms and was diagnosed with panic disorder. The nurse referred him to the prison doctor.

38. The doctor examined the man the following morning, and he told the doctor that he was worried about having prostate cancer. His blood pressure was within normal range at 117/76, his pulse a high at 104 but regular and he was diagnosed as having had a panic attack. The doctor reassured him that if his prostate symptoms continued, he would review in four days. He was prescribed ibuprofen at 4.25pm later the same day for a headache.

Events on 24 May

39. In response to our notice to staff following the man's death, a volunteer from the chaplaincy team contacted the investigator by telephone. She explained that she had been running the Alpha course (a course for people wanting to explore the Christian faith) which he had commenced the week previous. She had gone onto B wing to distribute reminder notices for the course during the lunchtime period. She explained that she must have seen him "minutes before he collapsed" through the cell window. They had a short discussion about the content of a prayer about relationships that was said the previous week, and she agreed to discuss more fully the following day during the Alpha course. She told the investigator that he did not complain of feeling unwell and, although her view through the cell door was limited, she did not detect anything untoward.

40. An officer was unlocking each cell after the lunchtime period at approximately 1.40pm. She could not remember specifically, when the man pressed his cell bell. During an informal interview, the officer told my investigator that at the point he pressed his cell bell, she was just about to unlock his cell so was able to immediately respond. She explained that he told her that he needed a nurse as he did not feel well, that he had slurred speech and he had pain all over his body. As she did not have a radio, she stayed with him to provide reassurance and shouted to a SO, to request urgent healthcare assistance. The SO used his radio, requesting a 'code one' response from healthcare (this is an indication that urgent emergency help was being requested).

41. Two healthcare staff responded straightaway. The man was found to be anxious and agitated, was able to speak but his speech was slurred. A doctor entered the prison for his duty at 2.00pm and was immediately alerted to an incident on B wing. He responded and went directly to B wing, he was advised by a healthcare colleague who was assessing the man that there had been some previous concerns that he was suffering from anxiety.

42. The man described to the doctor feeling a "large buzzing throughout the front of his head", and said that he had immediately pressed his cell bell but the

sensation had subsided. The doctor examined him, his pupils were equal and reactive to light, he did not have a rash, his reflexes were "brisk" (not normal) and he had expressive dysphasia (difficulty communicating due to a possible brain injury or muscular damage to the mouth). His blood pressure was recorded as 113/96 (within normal parameters), pulse a little high at 88 and he was unable to sit upright without support.

43. An emergency ambulance was requested to take the man to outside hospital at 2.06pm, as the doctor diagnosed a cerebrovascular accident (CVA, also known as a stroke. A stroke is a rapidly developing loss of brain function due to a disturbance in the blood supply to the brain). The ambulance arrived at Brixton at 2.22pm and he left Brixton at 3.03pm. In interview, the doctor said:

> "…with any prison is due to the regime we possibly don't have the quickest response time with ambulances compared to a community where they don't have security or multiple steps to pass through in order to call an ambulance…I think that's a question that's familiar to all of the prison estate…Anecdotally we tend to have a first responder on sight quickly; I think the Ambulance Service are very well tuned into the problems of prisons".

44. The man was taken to hospital. A risk assessment was completed that authorised a two officer escort and the use of restraints to be removed for emergency treatment purposes only with the duty manager's approval. He was taken directly to the accident and emergency department arriving at 3.20pm. He underwent a number of tests, including a brain scan, and a chest x-ray. He was assessed by a neurologist at 7.18pm and it was initially thought that he may have an infection, possibly bacterial meningitis and he was given antibiotics. During interview, the doctor confirmed that treatment of this kind would not have had a negative impact on his condition.

45. At 12.15am on 25 May, the man was moved to a ward and spent much of the next six hours sleeping. Intravenous antibiotics (injected into the vein) were again given at 7.40am, and at 9.36am blood was taken for further tests. He was conscious and able to communicate and at 12.26pm was able to eat a small amount of food. An Escorting Officer gained authorisation from the duty manager to contact the man's partner and nominated next of kin, to advise her of the situation and later sought authority for her to visit him at the hospital, which she did at 3.15pm. The man was advised by the doctor that he would remain in hospital overnight.

46. The following morning at 6.30am the man requested to use the toilet. He was weak and unable to walk. A nurse took his blood pressure, which was slightly raised and she informed the doctor. He had an electrocardiogram test (ECG - measures the electrical activity of the heart to help with diagnosis) and continued to receive intravenous antibiotics. Over the next few hours, he was able to eat some breakfast, but complained of having a headache. He was given paracetamol and further blood tests were taken. He was able to eat lunch and was told by the doctor that he would be having a magnetic resonance imaging scan (MRI – provides a clear picture of parts of the body

that are surrounded by bone tissue, such as examining the brain and spinal cord) at 3.00pm that afternoon. This scan was not completed as he was not able to remain still.

47. The man's partner visited him at 4.00pm. He had a bed wash at 4.15pm and he continued to receive intravenous antibiotics. At 5.24pm he suffered a bout of incontinence, nursing staff began to change his bedding, but at 5.30pm he became unresponsive. The emergency button was activated and a team of doctors arrived, who revived him.

48. Prison staff immediately contacted the duty manager at Brixton and were authorised to remove the restraints which they did. The ma was moved to a different bed and was receiving oxygen treatment, whilst being comforted by nursing staff. At 6.00pm he again became unconscious and the emergency alarm was activated. Following assessment by a team of doctors, he was taken for a computerised tomography scan (CT scan is a special type of x-ray using a scanner and computer equipment to take pictures of the brain or spine). Upon completion of this scan he was moved to the intensive care unit, but remained unconscious. Escorting staff were advised by the duty manager that restraints were only to be reapplied once he had regained consciousness.

49. Doctors placed the man on a life support machine and advised escorting staff at 9.55pm that he was dying but they were unable to give a life expectancy. His partner was with him at this time, and was told of the prognosis. Members of his extended family arrived at the hospital at 12.02am on 27 May. His condition remained the same and the hospital priest said prayers for him at his bedside. Throughout the night his partner and other family members stayed with him, his condition remained critical and he was deteriorating.

50. The Governor appointed a prison family liaison officer (FLO). The FLO arrived at the hospital at 7.30am on 27 May, introduced himself to the man's partner and other family members and was told that his cousin would be the family's representative. The Governor visited the man and his family at 10.30am. He introduced himself, answered some of their questions about prison protocols and explained that the FLO would be their first point of contact if they had any further questions or requests. The risk assessment was reviewed, and the escort was reduced to one member of staff who remained outside his room. Hospital staff advised that brain stem tests were being completed.

51. The prison was told at 11.36am that the man was very poorly and he remained ventilated. Further brain tests were undertaken to establish the level of activity in the brain and his family were advised he would not be able to breathe without the aid of a ventilator. He was pronounced dead at 3.45pm with his family at his side.

52. The FLO maintained contact with the man's family. On 31 May, in accordance with PSO 2710 'Guidance and instructions for actions to be taken following a death in custody', funeral expenses were offered and the family accepted the opportunity to visit his cell. Initially, the family were unable to

make the planned visits to Brixton, but a family member visited on a later occasion. All of his property was returned.

53. A post mortem was undertaken but the final report is not yet available. Initially, the cause of death was inconclusive, and more tests were conducted. An interim report by a Consultant Neuropathologist dated 29 June, summarises the findings. The clinical reviewer has had sight of this interim report and has confirmed that the findings in his clinical review remain unchanged and it is probable that the man died from an acute sudden bilateral cerebellar infarction (a stroke). The funeral took place on 21 July. The family agreed that the FLO and a prison chaplain could attend the funeral to represent the prison.

ISSUES

Clinical care

54. The man was only at Brixton for forty two days when he died of natural causes, experiencing a sudden and unpredictable event. He had disclosed an ongoing medical condition with his prostate, although this was not life threatening and he suffered from panic attacks. Neither of these conditions, according to the prison doctor and the clinical reviewer, were relevant to the circumstances of his death and were coincidental.

55. The clinical reviewer was commissioned by the local Primary Care Trust to review the medical care that the man received whilst in prison custody. His clinical review looks at the care and treatment he received at Brixton and measures whether it was appropriate and comparable to that which is available in the community. The clinical reviewer and we are satisfied that the care he received was comparable. The clinical reviewer makes no recommendations, and notes several areas of good practice. In summary he says:

> "The clinical care of the man whilst he was in Brixton HMP was equitable with that in the wider community and in the opinion of the reviewer was good…The treatment received by him was timely and followed expected guidelines. We do not know what caused the final catastrophic event which led to his death, but the records suggest that the care provided was adequate"

56. During the initial health screening the man's blood pressure was not recorded. Further, there are entries made by other medical staff which are ambiguous and should to be more explicit.

The Head of Healthcare should ensure that all healthcare staff, irrespective of status, comply fully with the requirements for accurate and contemporaneous record keeping in accordance with the required standards of the General Medical Council and the Nursing and Midwifery Council.

57. On 24 May when the man became critically ill, the emergency ambulance was requested at 2.06pm, arrived at Brixton at 2.22pm and at hospital at 3.03pm. The clinical reviewer and the investigator considered the length of time the ambulance was at Brixton and whether this was reasonable or if there was any delay in transferring him to hospital for treatment. In addition to the inherent delays caused due to the security of a prison, the clinical reviewer established that the paramedics had to examine him, assess his vital signs, in addition to administering oxygen and gaining a venous access (used to administer fluids or drugs) in order to stabilise him and move him slowly to the ambulance. The clinical reviewer and the investigator are satisfied that there was no unnecessary delay in his transfer to hospital.

Prison family liaison contact

58. The man's family were at his bedside when he died. As outlined in PSO 2710, follow up to deaths in custody, it is desirable that a senior representative from the prison is appointed as prison family liaison officer. An officer was identified as the prison family liaison officer on the morning of 27 May and he attended the hospital. He explained the role of prison family liaison officer, PPO and the Coroner.

59. Financial assistance towards the cost of the funeral was made on 31 May. The prison family liaison role was carried out effectively, with compassion. The contact log was detailed and comprehensive. The FLO maintained good contact with all family members and was sensitive to the family dynamics. Along with a member of the chaplaincy department, he attended the funeral, representing Brixton, which he described as being welcomed by the family.

Prisoner support

60. A notice to prisoners was issued by the Governor the same day announcing the death of the man and expressing condolences. This notice reminded them of the available support, via wing staff, the prison chaplaincy and the listeners, Samaritans and was delivered to individual cells on B wing and displayed around the rest of the prison. He was remembered in prayers during the weekly service.

Staff support

61. A notice to staff was issued by the Governor the same day announcing the death of the man which reminded them of the available support, through the Care Team. Initially, a debrief (an opportunity to discuss events and review processes) was not held as he had died in outside hospital.

62. Following the investigators verbal feedback during the initial visit, staff were given the opportunity to discuss the events surrounding the man's death on 16 June. Unfortunately, a number of staff members were not able to make this meeting (one of the attending nurses works on a part time basis) or were unaware that it was taking place. We understand that some individuals were contacted directly by e-mail and that a staff information notice (SIN) was posted on the prison intranet on 15 June. Staff are personally responsible for accessing their e-mail and the intranet. However, access to computer terminals is often limited and the short notice meant that this opportunity to have a discussion was lost.

63. Giving staff the opportunity to collectively discuss an incident and reflect on all aspects of how it was managed provides those directly involved with an opportunity to process events. It can also be fundamental to providing the prison with feedback on any issues that need to be addressed as a matter of urgency (or indeed recognise good practice). We are disappointed that all staff reflected during interview that they would have welcomed an opportunity

to debrief. Although informally supported by their peer group, the prison had a duty of care to ensure the wellbeing of all staff involved.

64. Whilst the opportunity for a debrief some weeks after the man's death was offered, staff were not given adequate notice to ensure they could attend. We appreciate the difficulties in providing a debrief where all staff involved, either directly or indirectly, are available to discuss events. Again, this emphasises the importance of a full and prompt response.

65. With reference to the response to a death in custody, Prison Service Instruction (PSI) 08/2010 Post Incident Care says:

> "The manager responsible must ensure a suitable environment for the meeting, ensure that all staff involved in the incident are invited and given information about the meeting and ensure that staff who wish to attend are released from duty for sufficient time to attend the whole of the meeting."

The Governor of Brixton should ensure that all staff are provided with formal support from the establishment following a death in custody in line with the requirements of PSI 08/2010.

Record keeping

66. The man completed an induction, however, his induction records could not be located during the course of our investigation. Further, the CSRA form was also missing, and the investigatr could not confirm if it had been completed. In PSO 2710 Follow up to Deaths in Custody, paragraph 6.5 gives clear instruction that the prison is required to 'Hand over copies of all documents requested by the investigating teams'.

67. The most essential documents were available to the investigator in order for us to complete our enquiries. However, we have had cause to comment on this issue in a previous investigation relating to Brixton. This raises questions on the record keeping in relation to prisoners. It is vital that all documents for a prisoner are available and accessible to provide an accurate chronology of events, and to show the prison are trasparent about interactions regarding prisoners in their care.

The Governor should ensure that all documentation relating to a prisoner is available if requested during the course of any investigation.

CONCLUSION

68. The man's death was sudden and unpredictable. We are satisfied that he was treated appropriately during the time he was at Brixton. I agree with the clinical reviewer that he received care whilst he was in custody which was comparable to that which he could have expected in the community.

69. Despite the positive findings in this investigation, I have drawn attention to several procedural issues in this report. Regardless of the cause of death, or location, it is crucial that staff are given the opportunity to discuss events surrounding the death of a prisoner. The importance of offering staff support should be a priority for any establishment However, I do not think that any of these issues would have prevented a different outcome for the man.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that all healthcare staff, irrespective of status, comply fully with the requirements for accurate and contemporaneous record keeping in accordance with the required standards of the General Medical Council and the Nursing and Midwifery Council.

Accepted – *All the practitioners are aware of the need to ensure that there is good record keeping and documentation. There are annual documentation audits carried out to ensure compliance and audit findings are shared with the team through clinical governance and drugs and therapeutic forums. Ongoing.*

2. The Governor of Brixton should ensure that all staff are provided with formal support from the establishment following a death in custody in line with the requirements of PSI 08/2010.

Accepted – *SIN [staff information notice] published to inform all staff. Contingency Plans checked and includes guidance to be followed. Safer Custody Team to monitor/ ensure compliance. Better coordination agreed when planning staff debrief to ensure maximum attendance. Completed.*

3. The Governor should ensure that all documentation relating to a prisoner is available if requested during the course of any investigation.

Accepted - *Two new systems have been introduced. The CSRA and the prisoner's record are now held electronically in C-Nomis (NOMS prisoner records). The standard practice is that no prisoner/s moving to a different unit is accepted without a CSRA and the induction questionnaire completed as these guides single or shared cell occupancy. Completed*