Investigation into the circumstances surrounding the death of a man at HMYOI Brinsford in July 2009

Report by the Prisons and Probation Ombudsman for England and Wales

February 2010

This is a report of an investigation into the death of a man. He was 21 years old when he was found hanging one evening in July 2009, in his cell at HMYOI Brinsford. He had been in custody at Brinsford for nine months.

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

The investigation was undertaken by two investigators. I would like to thank the prison's Governor and his staff for their assistance. A clinical reviwer was appointed by the local Primary Care Trust to undertake a review of the man's clinical care. I would like to thank her for the review.

At the time of the man's death, staff at Brinsford were actively seeking to transfer him to an adult prison nearer to his family home in Manchester. He had refused to attend education some three months previously and, as a result, was on the basic level of the prison's Incentive and Earned Privileges scheme. This meant that he had no television in his cell, had restricted time with other prisoners and his pay was reduced. This investigation has considered the options available for prisoners who refuse to go to education classes. I make one recommendation to the Governor regarding this matter.

The clinical reviewer and the investigator have commented on the emergency equipment, in particular the defibrillator and oxygen. I have made a further recommendation to the Governor regarding this issue.

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.

Jane Webb
Deputy Prisons and Probation Ombudsman **February 2010**

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SUMMARY

The man had been in custody previously. He arrived at Brinsford on 7 October 2008 from HMPYOI Castington after being convicted at Crown Court for robbery and grievous bodily harm in April of the same year. He remained in touch with members of his family through regular telephone calls and letters but had not received any visits.

Staff noted that he tended to keep himself to himself. He was always respectful to them and appeared to be progressing well. However, he did not mix or associate with his peers. He was allocated to a single cell which was furnished with bunk beds.

Some two months before his 21st birthday, when he moved to a different residential block, he started to refuse to attend education. As a result he was downgraded to the basic regime under Brinsford's Incentives and Earned Privileges Scheme (IEP). This meant that he lost the use of a television in his cell, had restrictions on association with other prisoners and his pay was reduced.

The staff tried to encourage him to resume going to education and to understand why he refused, but he would only say he had a 'beef' down there. An officer spoke at length to him on what turned out to be the evening before he died. The officer was concerned about him and contacted education and healthcare on his behalf. The officer wondered whether he might be able to undertake education in his cell. She also wanted someone from healthcare to check him as she felt he was unhappy.

He was found in his cell one evening in 7 July. Prisoners who were cleaning the landing noticed him in his cell hanging from the bunk bed. One of the prisoners pressed the emergency alarm button. Staff responded and were directed to the cell by the prisoners. They tried to resuscitate him but were unable to do so. He was pronounced dead by the paramedics at 7.49pm.

The prison's deputy governor, family liaison officer and chaplain went to his family's home in the early hours of the morning and told them of his death.

THE INVESTIGATION PROCESS

1. I appointed an investigator to conduct the investigation on my behalf. Notices were issued to both prisoners and staff, inviting anyone who might have information on the man's death to make themselves known to the enquiry. As a result several additional witnesses came forward.

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

3. Two investigators visited Brinsford on 14 July 2009 to open the investigation and visit the cell where the man died. All the prison documents were examined and copies of the relevant documentation were taken.

4. At the same time as the investigators were visiting Brinsford, the man's mother, her partner and his grandmother were also at the prison. The investigators met them, expressed their condolences and explained the investigation process. The man's mother raised a concern that her son may have been bullied by a female prison officer. The investigators agreed to consider this in the course of the investigation process.

5. Also during the opening visit, the investigators met the Governor, the Prison Officers Association (POA) representative, the Chair of the Independent Monitoring Board (IMB), the police investigator and several members of staff.

6. One investigator contacted the local Coroner's Officer and introduced himself and explained the investigation process.

7. Both investigators returned to Brinsford on 14 October to carry out interviews. Six members of staff and one prisoner were interviewed. Police statements taken on the night the man died and shortly afterwards have provided the investigator with additional information.

8. On 4 November, an investigator visited HMPYOI Swinfen Hall to interview two prisoners who were at Brinsford when the man died and who wished to speak to him.

9. An investigator also carried out a number of telephone interviews with senior staff at Brinsford and received emails clarifying points raised.

10. One of the Family Liaison team contacted the man's father by telephone. She explained the role of the Prisons and Probation Ombudsman and asked whether he had any concerns or questions that the family would like the investigators to consider. He mentioned an allegation that his son was bullied by a female prison officer. His

family commented that he had been very close to an uncle who had died in 2008 which may have distressed him.

11. A letter dated 11 December 2009 was received from solicitors representing the man's mother, asking if the investigator and family liaison officer would visit her to update her on the investigation. The family liaison officer contacted the solicitor and suggested a visit could be arranged after the family have the opportunity to consider the draft report.

12. A clinical review of the man's health care whilst he was in custody was undertaken by a clinical reviewer. She reviewed all the information and evidence about his healthcare whilst in the prison system. She completed a report for the local Primary Care Trust (PCT.

13. On 1 July 2010, one of my investigators spoke to a PO by telephone to clarify some points raised by the family.

HMYOI BRINSFORD

14. Brinsford is a young offender institution and a remand centre for juveniles and young adult prisoners up to the age of 21 years. It is purpose built to accommodate young people either on remand or awaiting appearance at Magistrates or Crown Courts or who are convicted or sentenced. It opened in November 1991, replacing the former Brockhill remand centre, and is situated on the same site as HMP Featherstone.

15. Brinsford forms part of the Prison Service's Juvenile Estate and holds those on remand and those sentenced under detention training orders (DTOs). From April 2000, it changed its role to accommodate a mixed population, including those under the age of 18. All juveniles are housed in separate residential units from other young adult prisoners. With effect from June 2008, the capacity for juveniles is 112 and the overall certified normal accommodation is 545.

16. There are five units. Unit One holds juveniles, both on remand and sentenced under DTOs. The other four units are for young adults aged from 18 to 21 years. In addition there is a healthcare unit with 11 beds and an Intervention and Assessment Unit (IAU) which has 16 beds

Incentive and earned privilege scheme (IEP)

17. The IEP scheme was introduced into prisons in 1996 as an incentive to reward good behaviour. There are three levels which are basic, standard and enhanced. The incentives include access to in-cell television, more private cash to spend, wearing the prisoners' own clothes, more time out of cells and community visits. Each prison sets its own criteria for prisoners to obtain each level. Young offenders who refuse to attend courses at Brinsford, including education classes, are downgraded to basic regime.

18. A prisoner who is on basic regime is subject to regular monitoring. They are allocated a personal officer who is expected to work closely with them to encourage them back to the standard level. They are reviewed on a weekly basis by the wing senior officer (SO). The prison's IEP Board, which consists of the prisoner, wing senior officer, wing officer and, where possible, an IMB member review basic level prisoners after 28 days and then fortnightly thereafter.

19. The guidance within Brinsford's IEP policy document states, 'Level 3 must be used sparingly and only when all other forms of intervention have been exhausted'. However, a further note to the strategy for managing young adults/young people who refuse to attend scheduled activities states. '*Where a young person or young adult refuses to attend his activity, he is not permitted to attend a different activity.'*

20. Since 2004, when the Ombudsman became responsible for investigating deaths in custody, there have been two previous deaths. Sadly, since the man's death another young man has died which is also the subject of an investigation from this office. The previous deaths had no similarities to the man's, although the recommendation regarding the defibrillator issues was made previously.

Independent Monitoring Board Report (IMB)

21. Each prison in England and Wales has an Independent Monitoring Board responsible for monitoring day-to-day life in the prison and ensuring that proper standards of care and decency are maintained. The Board's most recent report for 2007-2008 highlights general improvements in the conditions at Brinsford. Part of their report focuses on learning and skills. They welcome the Rowan Unit which opened in May 2008 with workshops for painting, decorating and bricklaying.

22. However, the Board raises concerns about allocation of classes and prisoners' late arrivals, as well as prisoners being sent to classes teaching courses which they have already completed. The IMB was also concerned by the requirement for young offenders over the compulsory school age to attend education as part of the IEP scheme. This is a particular concern if prisoners have to repeat courses more than once.

23. Overall, the IMB felt Brinsford was moving forward and the conditions for both prisoners were improving.

Her Majesty's Chief Inspector of Prisons (HMCIP)

24. The last visit HMCIP made to Brinsford was a formal inspection of the juvenile unit in 2008. Prior to that there was an unannounced inspection of the young offenders' estate in 2007. In this report HMCIP noted that young people did not have enough time out of their cells. Access to association and exercise in the fresh air was inadequate and there were insufficient activity places. Education accreditation had improved but vocational training was limited, and attendance at classes was poor.

25. The establishment was judged not to be performing sufficiently well against the healthy prison test. Included in the report's recommendations was one which said, 'Attendance at education should be improved'.

KEY FINDINGS

26. The man was born in 1988 and lived with his mother in Manchester. His father lived in Kent. He had been convicted before and been in custody in a YOI previously. He had not been assessed as at risk of self harm or suicide during his earlier sentence.

27. He was sentenced at Crown Court on 15 April 2008 for an offence of grievous bodily harm and robbery. He was initially sent to HMP Forest Bank where he was assessed by the reception and first night staff, which included an initial medical screening. No issues were identified and he was not considered to be a risk to other prisoners nor at risk of suicide or self harm.

28. On 12 May, he transferred to HMP&YOI Castington where he underwent another initial screening. A secondary health screening was partially completed with him the following day and his weight was noted to be 79 kilograms. No other physical or medical issues were apparent and no risks were identified. He remained at Castington and appeared to be doing well.

29. After five months, he moved to Brinsford on 7 October 2008. An entry in his medical notes indicated that he was well, with no medical problems and he declined to see a doctor. (There was no reception health screen document initiated by Brinsford in his medical notes, therefore no medical observations were taken including his weight.) He was placed on a residential wing and allocated to go to education as part of his sentence planning. His attendance at education formed part of his IEP contract.

30. On 10 October, a, initial classification and allocation of young offender form (ICA) was partially completed. (This form offers information on the allocation of prison place and forms a part of the offender's sentence plan.) The document noted that he had a long sentence of three and half years to serve in a closed prison. He had no drug or alcohol issues and was due to go to Stoke Heath and would prefer to be there than Brinsford.

31. There is documented evidence in his Offender Assessment Systems document (OASys), that his offending behaviour was linked to alcohol use. (An OASys records the offending personal and offending behaviour together with risk assessments.) It was further noted that he told the officer that he was not expecting to have visitors. However, he did maintain contact with his family through letters and telephone calls.

32. He appeared to settle into the routine at Brinsford. He was a very quiet young man who tended to keep himself to himself. He did not pose any problems to staff or other prisoners and did not appear to make any friends. He received good reports from education. A tutor in education wrote in his wing record on 7 January, 'He is doing

consistently well in education. He attends regularly, completes all work with a good attitude and is polite to staff'.

33. On 12 January 2009, an entry in his wing file booklet noted that a sentence planning meeting had been held with him, his probation officer from Manchester, by telephone, and an Offender Supervisor. She wrote that targets had been identified. These included to achieve and maintain enhanced status through the IEP scheme, to continue with negative results under the voluntary drug testing scheme, to remain adjudication free, to follow with assessments for offending behaviour courses and to look at vocational courses in plumbing. All the targets would be reviewed in six months time.

34. Good comments were regularly made in his wing record throughout January and February. No problems were either raised by him or noted by staff. On 27 March, he moved residential wings and was allocated a single cell furnished with a bunk bed.

35. Three days later, on Monday 30 March, he refused to attend education. An entry on his wing record by an officer says 'he has a beef down there'. There does not seem to have been any attempt to discover exactly why he refused to attend education, despite the fact that he had been regarded as a 'model' student.

36. A week later, still refusing to attend education, he was downgraded to basic regime according to Brinsford's IEP policy. This meant he had a number of privileges taken away, including the television from his cell, restricted association and his access to exercise was restricted. Comments by staff to the investigator indicate that they did not think he was bothered by the punishments.

37. Throughout April, May and June he continued to refuse to go to education and, as a result, he remained on the basic regime. Various comments were recorded in his wing record ranging from him 'having a beef' to peer problems. No one appeared to have explored them fully with him or to have considered offering a class other than education.

38. He had regular weekly IEP reviews throughout April, May and June. On 3 June his personal officer noted that he was now attending regimes and had been placed on a standard IEP. However five days later, Officer A wrote in his wing file booklet that he had refused to go to education saying he had a headache, was troubled off the unit and a senior officer had said he could stay in his cell until he was transferred from Brinsford. He was unable to identify the senior officer, so the officer warned him he would loose points on his standard IEP and removed the television set from his cell.

39. Both his personal officer and the wing SO encouraged him to return to the education department but he consistently refused. The wing record of the reviews invariably said, 'Refuses to attend education as he has a

beef there' or something very similar. However, it was also noted that he was polite to staff and his behaviour did not cause any problem.

40. On 9 June, a Senior Officer (SO) completed an IEP review document with him. It was noted that whilst he was compliant with four review points, interaction with staff and peers, maintaining his own hygiene, and that of his cell. However, he was non compliant with regime participation, by refusing to go to education, therefore he was demoted back to basic IEP. It was recorded that he accepted this decision but he would make an effort to resolve his issues down in education.

41. Several staff said in interview that efforts were being made to move him to a prison nearer to his home in Manchester. As he was 21 years old, he would have to leave Brinsford and transfer to an adult prison. There had been several enquiries to prisons in the Manchester area to see if they could take him, but nothing had become available.

42. He spoke regularly to his family on the telephone. All telephone calls made by prisoners are recorded by the prison. These calls can then be monitored if the Governor feels it appropriate. Most prisoners' calls are not routinely monitored, but are sometimes randomly checked. His calls were not monitored.

43. On the evening of July 6, Officer A had a lengthy conversation with him. She was concerned about him and so, when they finished talking, she sent two emails. The first was to the education department asking for some work that he could undertake in his cell. The second email was to healthcare asking how to initiate a mental health review for him, as she felt he was depressed. In interview for this investigation, she said that he had lost weight and was stressed about something, but would not speak to her about it.

44. The officer said that she had no immediate concerns about him and, if she had, she would have opened an Assessment, Care and Custody Teamwork (ACCT) document. (This is the Prison Service process for monitoring prisoners considered to be at risk of suicide or self harm.) She also said that, in those circumstances, she would have brought the prisoner to the attention of her line manager.

Day of the incident

45. One morning in July he still refused to go to education and so he remained in his cell. He came out during the day to collect his meals and spoke briefly to Prisoner A. The prisoner told the investigator that he was his usual self and there was nothing unusual about his appearance or attitude. The prison records show that the routine was exactly same on this day as every other.

46. At about 7.00pm most of the prisoners were locked in their cells. He shouted to the next cell asking if the prisoner had a cigarette but there

were none to spare. About 25 minutes later a prisoner, who was on the landing carrying out cleaning duties, looked into his cell and saw him hanging from the bunk bed. He called to another cleaner who checked and they then raised the alarm by pressing an emergency bell.

47. Prison staff responded to the alarm. The prisoners on cleaning duties said it seemed to take a while before staff arrived on the landing and were directed to his cell. The reason for the apparent delay in getting to the cell was because the alarm rings across the entire residential wing and staff have to check all the landings to find out where they are needed. At about 7.30pm Officer B opened the cell door and went in with Officer C. Officer C cut the ligature and Officer B lowered him to the floor. They were joined by Officer C, who started cardio pulmonary resuscitation (CPR) with Officer B.

48. Officer C was relieved by a nurse, who ordered a code blue alert. (A code blue alert informs staff that a prisoner requires emergency aid and the injury is from hanging. It also alerts the nursing staff to bring the necessary equipment.) The nurse assisted administering CPR at the rate of 30 compressions to two breaths.

49. The staff were joined by two more nurses, who took over CPR from Officer B. About five minutes later another nurse arrived with the defibrillator and oxygen. They followed the instructions from the defibrillator. The defibrillator advised them not to shock but to continue CPR. When the emergency paramedics arrived, having been called by the prison control room, they took over. The paramedics continued to treat him but were unable to resuscitate him. At 7.49pm they stopped resuscitation. His cell was locked and the police were called.

50. The prison's family liaison officer, the Deputy Governor and the prison chaplain left the prison at approximately 11.15pm to visit the man's family in Manchester to break the news of his death. They arrived at about 1.15am and met the local police. The prison staff contacted the family by telephone and were then invited into their home, remaining until about 3.20am.

51. The man's father, who is estranged from his wife, was contacted by telephone and again the following day. The prison has maintained in touch with him, but his mother did not want the prison to contact her again.

52. On 14 July the man's mother and family members visited Brinsford. They were met by the family liaison officer and the deputy governor. The family spent time on the wing, spoke to wing staff and a friend of the man. Later, they visited his cell. (Prior to the family visit the cell had been cleaned by two prisoners and a television set had been placed in the cell.)

53. Support was offered to prisoners on the wing, but it appears that in some cases it was not followed up. A prisoner, now at HMYOI Swinfen Hall, is receiving support there following the death.

54. A de-brief was held for staff later that evening and a further critical incident de-brief was held the following week. Staff interviewed as part of this investigation confirmed that they had been offered support by members of the care team and one officer said he was still receiving support.

55. A post mortem was held by the Coroner for Staffordshire on 14 July 2009. He concluded that the man died as a result of hanging and the marks on his neck were consistent with a ligature. He said there was no evidence of external violence or any pre-existing disease which would have contributed to his death. An inquest will be held during 2010.

ISSUES

Incentives and Earned Privileges Scheme (IEP)

56. Prison Service Order (PSO) 4000 lays out the rationale for the incentives and earned privileges scheme. It sets out the required actions relating to IEP and gives guidance on devising, managing and monitoring local schemes. It also sets out the policy for televisions within cells. The PSO has two mandatory actions. The first is that the scheme must operate on at least three tiers which are basic, standard and enhanced. The second mandatory action is that on entering custody, all prisoners must be placed initially on the standard level and a review undertaken within the first month.

57. Brinsford has its own local policy which was reviewed in March 2009. It follows the guidance in the PSO and operates at three tiers, that is level 1 which is enhanced, level 2 which is standard and level 3 which is basic. The system includes daily assessments of the following categories and points are awarded according to the prisoner's performance. The criteria include the prisoners' interaction with staff and other prisoners, the cleanliness of their cell and their personal appearance and hygiene. The prisoner is also judged on their attendance at activities and their performance whilst they are at activities linked to the sentence or training plan targets together with their cooperation with the prison rules. An appeals process is included within the policy.

58. It is noted that on 9 June, an IEP review by the SO recorded that the man had achieved four standards out of five. The fifth being his refusal to attend education. Seemingly, he was compliant with four of the standards. The SO also noted that he was in agreement with remaining on basic level. However there was nothing recorded about any alternative regimes being offered to him, given his age, and reluctance, to assist him in addressing his refusal to go to education.

59. From his arrival at Brinsford up until the end of March 2009, he was on the level 2 standard regime. After 30 March, he refused to attend education and was moved to level 3 basic regime. This meant that his television was removed, his pay was reduced and association restricted.

60. He spent the majority of the next three months until his death on basic regime. He was adamant that he would not attend education which, even though he would not have been compelled to attend education in the community, was a requirement of his IEP contract. The staff and prisoners interviewed for this investigation have said that being on basic did not appear to bother him at all. They describe him as a quiet and respectful young man who kept himself to himself and did not mix with his peers. He gave a number of excuses for refusing education and appeared happy to spend most of his time in his cell sleeping.

61. The prison records show that his IEP status was subject to regular reviews as required by the prison's policy. The reviews were held every week with his personal officer and the wing SO and the results documented in his prison record.

62. The Ombudsman's Office has investigated a number of deaths involving prisoners who were on basic regime. In the man's case the investigation cannot determine whether this was a factor in his death or not, but from interviews with staff and other prisoners, it would appear that he was content to remain on basic regime.

63. The investigator spoke with the Head of Young People at Brinsford to ascertain what options were available for a prisoner such as the man, who consistently refuses to go to a class. He said that all young adults undertake programmes which are linked to their sentence plan. Individuals can apply for certain courses, but offers of places are subject to vacancies being available. Even if places are restricted, the courses continue to be advertised through notices and posters and the prisoners apply via the allocations department.

64. There seems to be little flexibility for individual prisoners and the chance of obtaining alternative courses seems to be limited. Thus, as in this case, the prisoner may refuse a course but is not offered an alternative and so is downgraded to basic level.

65. Prison Service Order (PSO) 4205 details the guidance and mandatory requirements regarding how education is to be provided to prisoners. Prisoners of compulsory school age must be provided with education and other prisoners should be encouraged to take part. Young offenders are catered for under Rule 35 which states that their classes will be provided during the normal working week supplemented where practicable, by evening and weekend classes or private study.

66. According to Her Majesty's Chief Inspector of Prisons, Brinsford has a good education department and the majority of young offenders are allocated courses there. However there are insufficient alternative activities for young offenders who are over the compulsory school age and who do not wish to further their education.

67. The IMB reports on the problem of young prisoners being allocated to education and allocated to courses that they have already completed. This was confirmed by two prisoners interviewed for this investigation. Both stated that they had completed the same courses on several occasions and that there is a lack of practical courses.

68. It was also noted in minutes of the violence reduction meeting of 17 June 2009, with reference to the behaviour of another prisoner, that there were staff shortages within psychology and programmes and fewer effective regimes were running at that time. The man had

completed the Enhanced Thinking Skills course. One of his sentence plan targets set in January 2009 was to look at a vocational training course in plumbing. However, there is nothing recorded that this had been pursued on his behalf.

69. I believe that prisoners should benefit from education and so there should be more alternatives available. I can empathise with a 20 or 21 year old required to undertake education but would not have to do so outside prison. Brinsford should explore this further and see what can be offered to those over the compulsory school age.

The Governor should explore the activities other than education which can practicably be offered to those over compulsory school age.

Bullying

70. The man's family and a friend told the investigator that he said he was verbally bullied by a female staff member. There was no indication when this occurred or the identity of the officer.

71. Brinsford has an Anti-Bullying Strategy whose objective is to record and deal with allegations of bullying made by prisoners against fellow prisoners. There is no record of him ever making use of this strategy during his time at Brinsford.

72. The Independent Monitoring Board (IMB) will investigate complaints by prisoners, including allegations against members of prison staff. The IMB Chairman said that they have no record of him making any complaint to them during his detention at Brinsford. They were aware he was on basic regime as they took part in the monthly reviews and they would have seen him on the wing, but he did not complain to them about bullying.

73. He refused to attend the education department after 30 March 2009 which was when he moved residential blocks. Up until this point his reports show that he had a good rapport with staff and he appeared to be progressing well. From then on, he made a number of excuses for refusing to attend education including peer pressure, a 'beef' with someone there and other reasons. His personal officer and other staff attempted to find out why and encourage him to return, but he consistently declined. The IEP reviews also explored his refusal to attend education. Enquiries were made of the education department, but nothing was discovered to indicate bullying or peer pressure.

74. Officer A worked on his wing. She is an experienced prison officer and been at Brinsford for nearly nine years. She told the investigator that she had regular contact with him during June until his death. She found him a pleasant and courteous young man. They had a common interest as she had worked at Manchester before Brinsford. She felt

that he would talk relatively openly to her, although he remained guarded. She too tried to understand why he refused to attend education and he made the same excuses of peer pressure and the like.

75. She explained that she was concerned that he had nothing to do in his cell and she wanted to encourage him to do something. She wanted someone to assess him as he was spending all his time in his cell. She thought he might speak to a nurse more openly than an officer. Also the nurses were younger which she thought might help him to relate to them.

76. I appreciate his father's concerns that his son was bullied by a member of staff and have attempted to discover whether this was the case and whether it might have been the reason why he harmed himself. The investigation has found no evidence to support the allegation of bullying. Although I make no recommendations concerning the matter, I draw it to the Governor's attention. I expect that he will draw it to the attention of the IMB Chair and those responsible for implementing the Anti-Bullying Strategy. They may wish to review their procedures to ensure that they are effective.

Bunk beds in single occupancy cells

77. When the man moved cells on 30 March he was allocated to a single cell furnished with a bunk bed. The investigator was told that the bunk beds were retained in case additional prisoners had to be accommodated. Concerns about the bunk beds were first expressed to the Deputy Governor when the investigation was opened soon after his death.

78. The investigators returned in October and found that the bunk beds were still in place. One investigator repeated his concerns to a governor and recommended that they should be replaced. The governor responded that removing the bunk beds would not prevent a prisoner using an alternative ligature point and would not make them into safer cells. (Safer cells are designed to specific Prison Service standards and are free of ligature points. They are used to accommodate prisoners who have been assessed as at risk of harming themselves.)

79. However, following the subsequent death in which another young man took his own life in exactly the same cell and again from the bunk bed, the governor decided that all the bunk beds would be converted into single beds within four weeks. This has been done and as a result I make no formal recommendation. I am however disappointed that another death took place before the investigator's recommendation was accepted.

Clinical care

80. An independent clinical review was undertaken by a clinical reviewer on behalf of the local PCT. She examined the medical records relating to the man's time in HMP Forest Bank, HMP&YOI Castington and HMPYOI Brinsford.

81. The clinical reviewer refers to the delay getting the oxygen and a defibrillator to the cell. The alarm was initially operated by prisoners who were cleaning the wing and they directed the prison staff to the cell. The staff immediately cut him down and commenced cardio pulmonary resuscitation but did not immediately report it as a code blue emergency. As a result the nursing staff did not bring the defibrillator or oxygen. The first nurse to arrive then called a code blue and, some five minutes later, another nurse arrived with the necessary equipment.

82. CPR was continued by the emergency paramedics, but he could not be revived. Although the clinical reviewer refers to the delay getting the emergency equipment, she qualifies her comments by stating that it was unlikely to have affected the outcome for him. Nevertheless, in other such situations, the prompt use of the defibrillator and oxygen might mean that a prisoners' life can be saved.

The Governor and Head of Healthcare should consider providing additional defibrillators and oxygen positioned around the prison.

83. When the man first arrived at Castington on 12 May 2008 his weight was noted to be 79 kilos. The post mortem report recorded his weight to be *72* kilos and he was underweight. Officer A observed that he looked as if he lost weight on 6 July, when she raised her concerns in the email asking for an initial mental health assessment.

84. The officer acted correctly in raising her concerns over his mental health as, together with his weight loss, he was spending many hours alone in his cell sleeping, with no television. However, the officer did not consider him to be in danger of self harm and an ACCT document was not opened.

Family Issues

85. Following the man's death, his mother was given the contact telephone number of the deputy governor. When she telephoned the deputy governor, the day after his death, his mother said the number she was given was answered by a cleaner, who was unable to help her and said the deputy governor was not on duty. She was then left with no one to speak to.

86. The man's mother and family members visited Brinsford to meet with staff, prisoners and visit his wing and cell. Prior to the visit the family had not been made aware of security issues for entering a prison and that they would be searched. On their arrival at the prison they found this to be distressing as they were not expecting the routine of a bag and body search.

87. Their overall impression of the visit is one of insensitivity with one officer they described as lacking compassion. They met one of the man's friends in the company of many officers. The family felt the friend seemed nervous and intimated by the presence of the officers. They were also told by prison staff that they could not enforce other prisoners to meet with the family.

88. When they visited his cell they had expected it to be in the same condition as when he died. However, it is evidenced that two prisoners were asked to clean and tidy the cell before the family visit and replace the television. The man's mother told my family liaison officer that prison staff assured her it had not been cleaned prior to their visit.

89. She further felt that the prison mislead when she asked questions including when she found that prisoners ate their meals in their cells as opposed to eating in a dining room. She had been lead to believe that her son had taken his last meal in a dining room.

The Governor should ensure that family liaison officers are trained to the standards in PSO 2710 and adhere the guidance set out in the order.

90. The man's father asked for the time when his son's body was taken from his cell and transferred to hospital. The log of events, a document that records all those people that enter the cell from the first alarm being raised until the closure of the incident, indicates that he was taken, by undertakers, to hospital at 00.50am.

91. Brinsford's death in custody contingency plan had been opened and in accordance with PSO 2710, police officers, police forensic officers, senior prison staff and a doctor to confirm death, had to ensure that all guidance had been adhered to before the man could be taken from the cell to hospital. Whilst I can fully understand the distress of his family that it took five hours for the transfer to take place, there has to be a

thorough examination of the scene to ensure that evidence for the inquest is recorded and preserved.

The man's property

92. The man's mother was given back his property following the visit. However she has raised questions regarding items sent into Brinsford during his sentence. It was recorded that a CD was sent and received into Brinsford on 25 February 2009 and passed to reception. He did not receive the CD and made an application under the complaints procedure for the CD to be traced. A memo dated 15 March 2009, from a SO in Admissions, notes that the CD was collected by reception staff. However, it was not found in his property box or noted on his property card. The SO wrote that reception staff had investigated the loss of the CD but it had not been found.

93. Prisoners' property and complaints about property are dealt with under Prison Service 1250 and extract from the order says:

> "Complaints by prisoners about lost or damaged property, and claims for compensation, must be investigated in accordance with the Requests and Complaints procedure (PSO 2510 – particularly paragraph 12.4), and paragraph 5.9 of the Finance Manual PSO 7500."

94. There is evidence that the man's complaint was taken forward by the finance department in the memo to the SO. However, following the admission that the CD had been lost in the reception area of the prison there does not seem to have been any further investigation or offer of compensation.

The Governor should ensure that prisoners property is received, stored appropriately and lost property is dealt with in accordance with PSO 1250.

Response from prison family liaison officer

95. An investigator spoke to the prison FLO on 1 July 2010, to clarify some of the points raised by the man's family, following the circulation of the draft report.

96. He said that he was not aware that the family had been searched on their arrival at Brinsford. He could only assume that they entered the prison via the visitor's foyer where a search would have taken place. He had met the family at the gate area after they had first entered the prison.

97. Following a discussion in the Deputy Governor's office, the family met with officers and a friend of the man's. The officers were present at the

meeting with the friend to provide him with support at this difficult time and also as a security measure for the family.

98. The cell would have been cleaned and prepared for the next prisoner as soon as was practicable. There is pressure to ensure all vacant cells are available for occupation due to a shortage of accommodation.

99. The FLO added that the family were seemingly satisfied with their visit to Brinsford and thanked him for his help and support during the day.

CONCLUSION

100. This is a sad story of a young man who gave no indication that he intended to harm himself and had never done so before. He was a quiet and unassuming young man who kept a low profile at Brinsford. He was polite and, other than refusing education, caused no problems at all. Something made him decline to attend education after 30 March and he was downgraded to basic IEP level. I have found no reason for his refusal except perhaps for his age and that he may have already completed the course.

101. Being on basic regime meant that his daily life became increasingly limited and he had little to occupy himself. He remained on the basic regime for the next three months until he died. Although he was reviewed regularly, in many ways the meetings seem to have been perfunctory and certainly they did not result in any improvements.

102. His family made an allegation of bullying by a female staff member which I have explored but have found no evidence to substantiate their concerns.

103. One of the regrettable aspects of this investigation is that the place and the means by which he took his life have since been replicated. I appreciate that the bunk beds were not the only ligature point that he could have used. Nevertheless it is unfortunate that another death took place before the bunks were taken out of the cells.

RECOMMENDATIONS

1. The Governor should explore the activities other than education which can practicably be offered to those over compulsory school age.

2. The Governor and Head of Healthcare should consider providing additional defibrillators and oxygen positioned around the prison.

3. The Governor should ensure that family liaison officers are trained to the standards in PSO 2710 and adhere the guidance set out in the order.

4. The Governor should ensure that prisoners property is received, stored appropriately and lost property is dealt with in accordance with PSO 1250.