

**Report of an Independent Investigation into the Case of AC
commissioned by the Secretary of State for Justice
in accordance with Article 2 of the European Convention on
Human Rights**

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GLOSSARY

ACCT	Assessment, Care in Custody and Teamwork The care-planning system used to help to identify and care for prisoners at risk of suicide or self-harm
adjudication	the system for dealing with alleged breaches of prison discipline
Ambubag	the proprietary name of a bag valve mask, a hand-held device used to provide positive pressure ventilation to a patient who is not breathing or who is breathing inadequately
anti-psychotic	psychiatric medication primarily used to manage psychosis (including delusions, hallucinations, or disordered thought)
Basic regime	See IEP
BBV	blood-borne virus
CARATS	Counselling, Assessment, Referral, Advice and Throughcare Services
Care UK	Care UK is an independent provider of health and social care services in the United Kingdom. It works in close partnership with the National Health Service to deliver healthcare services.
Cat B [Category B]	the category of prisoners for whom the very highest conditions of security are not necessary but for whom escape must be made very difficult
citalopram	the anti-depressant drug prescribed to AC
CNA	Certified Normal Accommodation. (Uncrowded capacity is the Prison Service's own measure of accommodation. CNA represents the good, decent standard of accommodation that the Service aspires to provide all prisoners.)
Code 1	a call over the establishment radio network in a prison meaning a medical emergency
CPR	cardiopulmonary resuscitation
CSRA	Cell Sharing Risk Assessment

CSU	Care and Separation Unit. A dedicated unit within a prison where prisoners may be segregated in order to maintain order and discipline; to protect the safety of persons living, working or visiting the establishment; for their own protection; pending adjudication or as a punishment of cellular confinement following adjudication
DSH	deliberate self-harm
HMCIP	Her Majesty's Chief Inspector of Prisons
Hotel 6	the radio call sign for emergency response nurse
IEP	Incentives and Earned Privileges. The system for granting privileges to prisoners based on their behaviour. During the period covered by this investigation it operated on three levels: Basic, Standard and Enhanced. A fourth level was introduced in 2013.
IMB	Independent Monitoring Board
OASys	Offender Assessment System
Observation Book	Available to all staff on each residential unit. Entries are made about significant events for all prisoners and general observations. It is in hard copy form.
olanzapine	the anti-psychotic drug prescribed to AC when he first arrived at Brixton
OMU	Offender Management Unit
Outreach	small team of workers with mental health training (usually nurses) working between the Health Care Centre and residential units to support staff in managing prisoners on normal location deemed at risk of self-harm or with mental health needs
PCT	Primary Care Trust
P-NOMIS	Prison-National Offender Management Information System. HM Prison Service's computerised system.
PPO	Prolific and Priority Offender
PSI	Prison Service Instruction

psychosis	a severe mental disorder, with or without organic damage, in which the individual loses contact with reality. The main feature of psychotic illnesses is that they cause a person to have a distorted view of life.
SIR	Security Information Report
SLaM	South London and Maudsley NHS Foundation Trust
Standard regime	See IEP
SystemOne	a computerised clinical record system

Executive Summary

AC was remanded to HMP Brixton on 6 March 2010. Aged 36, he had a long history of substance misuse, mental health problems and offending behaviour. He had been in prison several times before, most recently the previous summer. AC had been looked after by one of his two sisters, LC, and was known to substance misuse and mental health services in the community. Although he was not formally diagnosed as schizophrenic, both AC and his GP in the community considered that his mental health was improved by his taking the anti-psychotic drug olanzapine.

AC was initially accommodated in C Wing and was promptly assessed by the medical services. The Substance Misuse Team arranged for him to receive a daily dose of methadone as a substitute for the heroin that he had taken in the community. Olanzapine was prescribed for ten days by the GP who saw him on his reception into the prison. The GP referred him to the Mental Health Outreach Team for an assessment which was carried out by a nurse on 8 March. AC asked to see a psychiatrist on 22 March. Following the assessment and his request, AC's case was not discussed by the Outreach Team until 29 April when the decision was confirmed that he did not meet the criteria to be taken onto their caseload. He was never to see a psychiatrist from the Outreach Team. His olanzapine was renewed on 13 March for three days but not thereafter.

AC moved from C Wing to G Wing on 15 March and shared a cell. He missed a number of appointments with the GP and the Substance Misuse Team.

On 29 April AC assaulted another prisoner, sufficiently seriously for the matter to be referred to an Independent Adjudicator who sentenced him to 21 additional days in prison. During the hearing, AC explained that he needed olanzapine but this information was not passed to the health services within the prison.

Following the assault, AC was moved from G Wing to A Wing where his mental health deteriorated. He was involved in a further assault on 22 May and was moved again, this time from A Wing to B Wing. AC's sister, LC, expressed to prison staff

her serious concerns about his worsening mental health and wrote a letter to the health care department stressing AC's need for olanzapine. AC's community-based GP spoke to his prison counterpart and the firm of solicitors acting for AC wrote to the Governor about AC's medication being stopped. Some of the prison staff were also increasingly concerned about AC's behaviour and condition; the Substance Misuse Team were concerned about his bizarre behaviour and sporadic compliance with methadone.

On 24 May, AC was assessed again by a mental health nurse from Outreach and this time his case was discussed rapidly with a psychiatrist and in the team meeting. An appointment was fixed for a psychiatric assessment on 2 June. In the meantime AC's behaviour continued to give cause for concern. He attempted to assault a prisoner on 27 May and was punished with loss of association, canteen (the ability to buy items) and television. He smashed up his cell on 1 June. AC did not attend the appointment with the psychiatrist on 2 June, very probably because staff were reluctant to unlock him because of the risk of violence that he was seen to pose.

On 4 June AC asked to move wings yet again but was initially refused. When he was brought his lunch at about 12.25, the officer noticed that he had made a noose out of a bed sheet and had barricaded his cell by moving a locker between the bed and the door. Other staff were summoned and tried to negotiate with AC. He was informed that he could move to another wing. Others attempted to remove the heel plate which enables the cell door to be opened outwards. One of the screws had been tampered with; a hard substance had been placed around it. After a period of placing the noose on and off his head while standing on the pipes at the back of the cell, AC started to hang – whether deliberately or accidentally it is not known. A locksmith from the works department (Carillion) was asked to attend and when he arrived he was able to remove the substance with a screwdriver and hammer and release the screw. Once the door was opened at 12.52, staff charged in, cut the noose, removed it and laid AC on the bed where cardiopulmonary resuscitation (CPR) was applied. Health care staff arrived shortly afterwards and took over. An ambulance was called and paramedics arrived at 13.09. AC was taken to King's College Hospital. He was granted bail on 10 June 2010.

AC is currently at the Royal Neurological Hospital in Putney. He is in a permanent vegetative state and is unlikely to improve.

Prior to this Article 2 Investigation, four investigations were carried out into the circumstances leading up to the incident of life-threatening self-harm, namely by:

- HMP Brixton
- Lambeth Primary Care Trust (Lambeth PCT) which commissioned health care in the prison at the time
- Care UK which was (and is) responsible for the provision of health care
- The South London and Maudsley NHS Foundation Trust (SLaM) which was subcontracted by Care UK to provide secondary mental health and substance misuse services.

There are a number of key issues identified by the reports of these investigations which are also considered in this Article 2 Independent Investigation. Among the most significant are:

- i) the quality of health care received by AC in HMP Brixton and in particular the failure by the doctors he saw to prescribe the anti-psychotic drug olanzapine;
- ii) the lack of effective communication
 - a) between the medical staff from Primary Care, Substance Misuse and Mental Health Outreach about AC's health care needs
 - b) between the medical staff and the uniformed prison staff who had day to day responsibility for AC.

- iii) the management of the incident of life-threatening self-harm by AC on 4 June 2010.

This Independent Article 2 Investigation makes 21 findings and 16 recommendations. Seven of the recommendations (A - G) are for the health care services in HMP Brixton; six (H - M) are both for health care services and HM Prison Service; and four (N - Q) are directed at the Prison Service.

Summary of Findings

- Finding One:** The seven-week delay between AC's assessment by the Mental Health Outreach nurse on 8 March 2010 and the case discussion by the Mental Health Outreach Team on 29 April 2010 was unacceptably long.
- Finding Two:** The delay between the Mental Health Outreach meeting on 29 April and its entry in the Medical Record on 10 May was too long.
- Finding Three:** It is important that decisions to discharge patients from the Mental Health Outreach Team are not taken by a nurse alone. When such a decision is taken it should be recorded immediately and communicated to the person who referred the case, in this instance the GP.
- Finding Four:** While AC's notes arrived reasonably quickly from the community GP practice, it is not clear the extent to which they were used to inform his assessment and diagnosis.
- Finding Five:** Although there were mechanisms in place for joint discussions about cases such as AC, coordination and communication between the Substance Misuse Team and the Mental Health Outreach Team could have been stronger in respect of AC's assessment, treatment and care.

- Finding Six:** AC's prescription for olanzapine should not have been stopped in the middle of March. The Mental Health Outreach Team should have made it clear to the GP who referred AC that their decision not to accept him on the caseload meant that he would not be prescribed any medication by them; and the GP should have asked the Mental Health Outreach Team to review AC's medication.
- Finding Seven:** When AC was discharged from Mental Health Outreach in March or when this was ratified on 29 April, a referral should have been made to the Primary Care Mental Health Team so that AC could have been supported by them. The PCMH Team should in appropriate cases offer to support to patients with substance misuse comorbidity.
- Finding Eight:** After the first ten days, the tripartite health care system in place failed to provide AC with the prescribed medication that he needed. A catastrophic lack of clarity about respective responsibilities led to a very poor level of medical care. This was compounded by poor communication between the various medical personnel who had contact with AC.
- Finding Nine:** AC's failure to attend his GP appointments should have been much more vigorously followed up by the Primary Care Team.
- Finding Ten:** AC should have been escorted by prison staff to his appointment with the psychiatrist on 2 June.

- Finding Eleven:** More effort could have been made by prison staff to identify what lay behind AC's unusual behaviour on the wing, including the nature and extent of his debts.
- Finding Twelve:** Prison staff made appropriate referrals to mental health in the second half of May but did not communicate to health care staff the problems AC was causing on the wing.
- Finding Thirteen:** The Independent Adjudicator who heard the disciplinary case against AC on 14 May should have alerted prison and health care staff to AC's self-reported distress.
- Finding Fourteen:** It is not absolutely clear whether AC was subject to a Perpetrator Plan and, if he was, what this entailed.
- Finding Fifteen:** There is an important discrepancy between what was told by Nurse C to the Care UK investigation and to us about whether he thought AC was subject to an ACCT when he saw him on 24 May.
- Finding Sixteen:** HMP Brixton failed to acknowledge the key role of AC's sister in his care or to engage constructively with her during his period in custody.
- Finding Seventeen:** It is not clear why the decision to move AC to G Wing seems to have been reversed during the morning of 4 June.
- Finding Eighteen:** Staff reacted well to the incident although it is not clear whether contingency plans for barricades were followed to the letter.

- Finding Nineteen:** On 4 June, the call to the locksmith should have been clearer about the level of urgency of the situation he was being asked to respond to.
- Finding Twenty:** After AC had made the noose and barricade, a Code 1 medical emergency call should have been made over the radio at an earlier stage. The ambulance should have been called at the same time as the Code 1.
- Finding Twenty-One:** Lambeth Primary Care Trust, Care UK and the South London and Maudsley NHS Foundation Trust (SLaM) should have commissioned a single investigation into the care of AC in HMP Brixton.

List of Recommendations

- Recommendation A:** The Mental Health Outreach Team should review any assessment undertaken by a team member within a maximum period of one week.
- Recommendation B:** The Medical Record should be properly updated within 24 hours of any action taken or decisions made.
- Recommendation C:** In the period between an assessment by the Mental Health Outreach Team and a decision about whether to accept a prisoner on to the caseload, a pending case should be subject to a provisional zoning priority. A system of monitoring and auditing compliance with the zoning protocol should be in place.
- Recommendation D:** Every effort should be made to gain access to a prisoner's medical records from his GP or local hospital within 24 hours of reception into prison.
- Recommendation E:** In a case where a prisoner has both substance misuse and mental health problems – so-called dual diagnosis – a joint assessment by a mental health and a substance misuse specialist should be carried out.
- Recommendation F:** Drug Dependence Reviews of dual diagnosis patients should consider the range of medication prescribed to a patient.

- Recommendation G:** The partners involved in providing health care to prisoners with mental health problems must be absolutely clear about which service or services have responsibility for prescribing anti-psychotic medication and develop systems to ensure it is prescribed in a timely fashion.
- Recommendation H:** A much more robust system should be in place to account for missed medical appointments. This system should explore reasons for non-attendance, emerging patterns of non-attendance and identify vulnerable prisoners. As happened with the Substance Misuse Team, two consecutive failures to attend GP appointments should trigger a visit to the patient in their cell.
- Recommendation J:** When a prisoner is identified as requiring assessment by a psychiatrist, he should be escorted to that appointment where necessary. If, for whatever reason, such an appointment is missed, medical staff should ascertain the reasons for the missed appointment on the same day.
- Recommendation K:** A multi-disciplinary system for managing Complex Cases should be in place to deal with prisoners such as AC who suffer from a combination of health and behavioural problems.
- Recommendation L:** When prisoners raise medical issues in adjudications, the information should be passed on to the appropriate health care services.

- Recommendation M:** Possible adverse consequences on a prisoner's mental health should be taken into account in imposing punishments and forfeitures at adjudications.
- Recommendation N:** We endorse the recommendation made by the Brixton internal investigation that, in the event of an incident of barricade or potential suicidal behaviour, contingency plans are managed by the Duty Governor. We would, however, add the proviso that this should not delay a response in an emergency.
- Recommendation O:** HMP Brixton should review the availability of a locksmith in the evenings and at weekends.
- Recommendation P:** Consideration should be given to placing 'Impact Screwdrivers' into each wing office to facilitate the removal of seized and damaged bolts on anti-barricade lock plates.
- Recommendation Q:** The daily cell fabric check should include the inspection of the securing bolts on the anti-barricade lock plates.

Part One. The Investigation

Chapter One

How we conducted the Investigation

The Investigation was carried out by Rob Allen, former Director of the International Centre for Prison Studies, assisted by Andy Barber, a retired Governor from the Prison Service. A Clinical Review was conducted by Professor Jonathan Warren and is annexed to this report.¹

The Investigation was commissioned on 18 December 2012. The terms of reference were:

- to examine the management of AC by HMP Brixton from the date of reception on 6 March 2010 until the date of his life-threatening self-harm on 4 June 2010 and in light of the policies and procedures applicable to AC at the relevant time;
- to examine relevant health issues during the period spent in custody from 6 March 2010 until 4 June 2010, including mental health assessments and AC's clinical care up to the point of his life-threatening self-harm on 4 June 2010; and
- to consider, within the operational context of the Prison Service, what lessons in respect of current policies and procedures can usefully be learned and to make recommendations as to how such policies and procedures might be improved.

¹ At Annex A

In the initial stages of the investigation, Andy Barber and I visited HMP Brixton to meet with the liaison officer on 18 January 2013 and met with AC's relatives at the hospital where AC is being cared for on 7 February 2013.

We analysed an initial set of documents which was disclosed to us. This included:

- the Brixton internal investigation report into the circumstances of the self-harm of AC prepared by Ms BB, the then Head of Psychology who was also Head of Safer Custody at HMP Brixton; commissioned on 4 June 2010 and completed on 30 July 2010²
- a report prepared by the South London and Maudsley NHS Foundation Trust (SLaM) into the care and treatment of AC; commissioned on 22 June 2010 and completed on 23 September 2010³
- a variety of other Prison Service records and other documents relating to AC's time at Brixton.

We obtained copies of two further reports that had been prepared about the case, namely:

- a Clinical Review undertaken on behalf of Lambeth Primary Care Trust (PCT) of the care received by AC; the report is undated.⁴
- a Root Cause Analysis Investigative Report prepared by Care UK, completed in January 2011⁵

(We refer to the four reports as, respectively, the Brixton internal investigation report, the SLaM report, the Lambeth PCT report and the Care UK report.)

² At Annex D

³ Ibid

⁴ Ibid

⁵ Ibid

We drew up a short paper setting out the sequence of events and the issues which we wished to explore in the investigation. We shared this with AC's sister, LC, with whom we met on 21 May 2013. LC agreed with our proposed approach, adding three specific additional questions. The first was about whether prison and medical staff failed to respond to AC's symptoms because they thought that he was feigning them in order to secure a 'medical hold' – that is a decision to remain in Brixton Prison after conviction on grounds of health care. The second issue relates to the urgency of the prison's response to the deterioration in AC's mental health after 22 May 2010. Finally, LC was concerned at an apparent delay in calling an ambulance. These matters are explored fully in Part Three of our report alongside the other issues which we identified.

We undertook a total of 13 face-to-face interviews with present and former members of staff at Brixton between June and September 2013. In addition, we undertook two telephone interviews and met with LC on 2 November 2013.

During the investigation we identified a number of additional documents and records from the prison that we thought might assist us. While we successfully obtained a number of these, there were some records that we were unable to see. For example, we were told that the records of telephone calls made by AC had not been kept, nor the list of people whom he was permitted to call. A list of documents we reviewed but have not annexed is at Annex O and a list of documents we requested but did not obtain is at Annex P.

The Clinical Review of health care, undertaken by Professor Warren as part of this investigation, is contained at Annex A. At appropriate points within this report we refer to Professor Warren's specific findings and recommendations. A timeline setting out the main events during AC's period in Brixton in 2010 is at Annex B.

Chapter Two

HMP Brixton

Brixton's original buildings date from the 19th century when it was designated as the trial and remand prison for the whole of the London area. In 2010 the Category B prison for adult males served a number of courts in south London and housed a mixture of remand and sentenced prisoners. In the summer of 2012 it was re-designated as a Category C/D resettlement prison. Its present function is therefore very different from that which it was carrying out during the period covered by this investigation.

According to a report by HM Chief Inspector of Prisons (HMCIP) on an inspection of HMP Brixton conducted in December 2010, Brixton's Certified Normal Accommodation was 503, its Operational Capacity was 798 and the usual number of prisoners during the year was between 725 and 775.

The prison comprises four main residential units, plus a Health Care Centre. At the time of the inspection A Wing housed 264 prisoners in 143 cells (mostly doubled, one for disabled), B Wing housed prisoners in 86 cells, some of which were doubled. C Wing housed prisoners in 69 cells (all doubled, one for disabled) and operated primarily as a first night centre and Vulnerable Prisoner Unit. G Wing housed prisoners in 151 cells (61 doubled, one for disabled) and looked after prisoners with substance misuse issues, operating as part of the national Integrated Drug Treatment Scheme (IDTS). D Wing had a 26 bed in-patient facility concentrating on acute mental health care.

The prison dealt with about 90 new receptions each week. Half of the prisoners it held were unsentenced and most had been in the prison for less than three months. Two out of five of the prisoners surveyed by HM Chief Inspector of Prisons in 2010 said they had a drug problem when they came into the prison – many more than in comparable prisons and more than when previously inspected in 2008.

At the time of the period under review, health care was commissioned by Lambeth Primary Care Trust, a body that ceased to exist in 2013. The Trust contracted with Care UK to provide the health services in the prison. Care UK subcontracted substance misuse services, in-patients and secondary mental health services to the South London and Maudsley NHS Foundation Trust (SLaM), and pharmacy services to Lambeth Community Care Trust. Care UK itself provided primary care (which included a primary care mental health team).

According to the HM Chief Inspector of Prisons' Report on its unannounced full follow-up inspection of HMP Brixton in December 2010, "The service ran as a consortium and from a prisoner's perspective there was little distinction between the service providers, which was to be commended."⁶

⁶ Report on an unannounced full follow-up inspection of HMP Brixton 1 – 10 December 2010 by HM Chief Inspector of Prisons, page 55. At Annex M

Part Two. Background and Events

Chapter Three

Background

AC was born on 1 January 1974 and led a troubled life. His first conviction was at the age of 17 and he had several spells in prison. He experienced a range of drug misuse problems and also suffered from mental health problems. AC had difficulty keeping stable accommodation and finding regular employment. He received a good deal of care and support from LC, one of his two sisters.

AC did not have a formal diagnosis of schizophrenia or psychosis although there is a reference in the medical records to admission to psychiatric hospital for assessment; however, it is not clear when this was undertaken. An OASys⁷ offender assessment carried out in February 2007 to inform a Pre-Sentence Report for the court noted that AC “previously demonstrated psychotic behaviour whilst in custody”⁸ and that he was placed in the health care wing due to mental health problems.

AC’s mental health gave the OASys assessor cause for concern, speculating that his behaviour could deteriorate. The assessor formed “the impression of a man who is more comfortable within prison than without.”⁹

A psychiatric assessment carried out in the community in June 2007 refers to a suggestion of “hearing a voice mumbling inside his head”¹⁰. The assessment thanks AC’s GP for continuing to prescribe olanzapine and citalopram and notes that there was a period when AC stopped taking the olanzapine in prison and felt noticeably

⁷ OASys: Offender Assessment System

⁸ OASys, 19 February 2007, Section 10. Annex E

⁹ OASys, 19 February 2007, Section 11. Annex E

¹⁰ Letter to Dr E, a community-based GP, from Consultant Psychiatrist in the community Assessment and Treatment Team, 26 June 2007. Annex F

different. “He felt more tense and with a great feeling of pressure and described seeing little figures which he thought were ‘driving me crazy’”.¹¹

Prior to his arrest on burglary charges on March 2010, AC had previously been in prison on a number of occasions, most recently at Brixton in August 2009. According to the SLaM report, AC had a total of 29 convictions.¹² He had been categorised as a Prolific and other Priority Offender (PPO), requiring specific measures of support and supervision and a named supervising officer within prison and in the community.

A risk assessment prepared by the police when AC was arrested on 4 March records AC as having mental health problems and taking “psychotic drugs for mental health issues”.¹³ AC was seen three times by a doctor while in the police station and prescribed 15mg of the anti-psychotic drug olanzapine on 5 March.

¹¹ Ibid

¹² SLaM report, page 10. Annex D

¹³ Police Risk Assessment. Annex E

Chapter Four

Arrival at Brixton, 6 to 15 March

AC was received into Brixton Prison on Saturday 6 March 2010. He had been remanded into custody following charges of burglary.

AC's mental health problems were identified at an early stage. On a disability questionnaire completed on 6 March, AC is recorded as having a disability and, in this regard, the box entitled 'mental health difficulties' is ticked.¹⁴

He was seen by Dr B, a prison-based GP who examined him as a new arrival. Dr B noted as a problem "Schizophrenia?"¹⁵ He referred AC to the Mental Health Outreach Team asking them to "assess and review as uncertainty remains re this patient's diagnosis"¹⁶. Dr B also noted that AC was "threatening self-harm to secure benzodiazepines".¹⁷

The Medical Record also records that AC was referred to the Substance Misuse and Blood borne Virus Teams. AC was prescribed olanzapine for seven days by Dr B.¹⁸

The Brixton internal investigation notes that a Cell Sharing Risk Assessment was undertaken and that AC was classed as high. AC was placed in C Wing in a single cell, 02-6.

On his second day in Brixton, 7 March, AC was assessed for drug use. Not only was his use of heroin and crack cocaine noted but also a history of self-harm, albeit at the age of 17. AC reportedly "Claimed to suffer depression but [was] unable to confirm

¹⁴ Disability Questionnaire. Annex E

¹⁵ Medical Record Printout, 6 March 2010, entry by Dr B. Annex F

¹⁶ Referral Form to the Mental Health Outreach Team, 6 March 2010. Annex F

¹⁷ Ibid

¹⁸ Prescription and Administration Record Charts, within Not in Possession Prescriptions sheet, entry on 6 March 2010. Annex F

his mental health diagnosis.”¹⁹ AC started on methadone, a substitute for heroin which is administered orally.

On his third day in prison, 8 March, AC was assessed by a member of the Mental Health Outreach Team, Nurse C, in his cell. Nurse C noted that this was a re-assessment – he had seen AC during a previous period in Brixton in 2009. It is not clear whether the nurse realised that AC had been released and readmitted to prison. The Medical Record notes AC’s longstanding drug misuse which was seen to lie behind his mental health problems. AC reportedly denied any intentions to harm himself but mentioned “mild auditory hallucination; male and female voice outside his head which tends to make him aggressive”.²⁰

The assessment proposed that AC be looked after by the GP and the Substance Misuse Team as his symptoms seemed “mild and not severe”. AC refused counselling and did not see the need for the Mental Health Outreach Team to contact his family. The case would be discussed at a meeting of the Outreach Team.

On 8 March, it was also noted that a request be made for AC’s medical notes to be obtained from the GP surgery where he was registered at home.

Two days later on 10 March, AC was seen at the Blood borne Virus Clinic. AC deemed himself at high risk because of sharing drug equipment; blood tests were undertaken and advice was given about using drugs in prison. AC denied using any drugs on top of the methadone.

Following these assessments, AC continued to have contact with the health care services, to obtain methadone and treatment for a skin rash. On 12 March AC missed a GP appointment, the first of very many that he missed during his time in Brixton. On 13 March, he was prescribed olanzapine for a further three days by a

¹⁹ Medical Record Printout, 7 March 2010. Annex F

²⁰ Medical Record Printout, 8 March 2010. Annex F

GP, Dr G. The box entitled 'Review Date' on the 'Not In Possession Prescriptions' sheet was left blank.²¹

A week after AC's arrival at Brixton, a further Cell Sharing Risk Assessment review was undertaken which found his risk to be low.²² On 15 March AC was relocated from C Wing to G Wing. He was placed initially in Cell 4-44 and from 17 March in Cell 2-25.

²¹ Prescription and Administration Record Chart, on the Not In Possession Prescriptions sheet, entry signed on 13 March 2010. Annex F

²² Dated 13 March and 15 March 2010. Annex E

Chapter Five

15 March to 30 April

During this period AC shared a cell. He missed a health care appointment on 16 March. Following a telephone call with the community GP practice, the practice faxed AC's medical notes to the prison on 18 March, although the community GP practice said that they had already faxed the notes [on a previous date]. On 19 March Dr B, the prison-based GP, issued a prescription for the anti-depressant citalopram for 28 days, but none for the anti-psychotic medication olanzapine.

On 22 March AC was seen by Nurse D from the Mental Health Outreach Team at his own request. AC was concerned that an upcoming court appearance might lead to a placement away from London, which would result in a loss of contact with his family and a deterioration in mental health. He asked to see a psychiatrist and it was planned to discuss AC's case with the team.

On 26 March AC told the GP that he had used heroin twice the previous week and his methadone dose was increased. AC missed a series of appointments with the GP (31 March), Blood borne Virus Clinic (24 and 31 March) and Substance Misuse on 1 April when he was due to be reviewed. On 4 April, AC was seen in his cell by a nurse and a member of the Substance Misuse Team, having failed to take his medication and methadone, although there appears to have been some confusion about the latter. AC said he did not need medication.

On 7 April AC attended court, refusing to take his methadone before he went but taking it when he returned. On 12 April he again did not attend an appointment to review his drug use and two days later he missed his third appointment with the Blood borne Virus Clinic. He did not keep GP appointments on 15 and 16 April.

On 16 April AC did speak with an Assistant Psychologist, Ms BD, who was his PPO Supervisor²³. She emailed the Mental Health Outreach Team and the Primary Care Mental Health Team on 19 March to inform them that AC had asked her if he could be referred to mental health services because he told her he had been diagnosed with schizophrenia and was suffering from depression.²⁴ The Primary Care Mental Health team responded to Ms BD by saying that they had not had a referral following the appointment with the Outreach Team in March. They added that considering that he [AC] is on methadone maintenance treatment, “we would normally expect Substance Misuse Dual Diagnosis worker to support him”.²⁵ The Team Leader of the Mental Health Outreach Team replied separately to Ms BD’s 19 March email. In his reply he mentioned the assessment that had taken place on 8 March and said that the story of his [AC’s] diagnosis cannot be validated as there was no record of him ever being admitted into any mental health unit. However, in his email the Team Leader continued, “I cannot rule out the possibility of him eliciting some psychotic symptoms which are likely to be induced by his drug usage.” He said that AC would be discussed “once again” in the “next referral meeting, where decision would be made regarding the appropriate services and support he would require whilst he is in custody.”²⁶

AC’s drug dependence review was finally carried out on 19 April when Dr BC, a Consultant Psychiatrist in the Substance Misuse Team, noted “nil suicidal. Mood ok” and increased his dose of methadone.²⁷

On 23 April, AC’s community-based GP, Dr E, sent a letter “To Whom it May Concern” at the prison, at AC’s request, supporting AC’s contention that transfer to a prison away from London would reduce family support and adversely affect his mental health.²⁸ The letter summarises AC’s long history of mental anxiety disorders and drug dependency, describing him as “a very vulnerable individual” and asks for a

²³ PPO: Prolific and other Priority Offender

²⁴ Email from Ms BD, PPO Supervisor/Assistant Psychologist to the Primary Care Mental Health Team, 19 April 2010. Annex F

²⁵ Email from Primary Mental Health Care Team to Ms BD, PPO Supervisor/Assistant Psychologist, 20 April 2010. Annex F

²⁶ Email from Team Leader, Mental Health Outreach Team, to Ms BD, PPO Supervisor/Assistant Psychologist, 20 April 2010. Annex F

²⁷ Medical Record Printout, 19 April 2010. Annex F

²⁸ Letter from Dr E “To Whom it May Concern”, 23 April 2010. Annex J

“medical hold” so that he could remain in Brixton to serve any prison sentence. The letter refers to the assessment made in 2007 which found “some suggestion of psychotic illness but formal diagnosis wasn’t made.” It continues, “It was advised to continue him on Olanzapine 50mgs pm which he takes. In the past he has also been on antidepressants, Citalopram, but he has not had a prescription recently”. The “50mg” is almost certainly a typographical error as the usual dose taken by AC was 15mg. It is not clear who at the prison read this letter from AC’s community-based GP when it arrived in April, nor what action, if any, was taken. A month later, the letter was one of three documents faxed by Dr E to the prison-based GP, Dr G, on 20 May 2010 following a telephone conversation between the two doctors on that day.

On 26 April, two Red Entries – warnings for poor behaviour – were noted on the prison’s newly-functioning electronic record system, P-NOMIS²⁹, because AC “does not follow clear instruction”.³⁰ The P-NOMIS system went live on 26 April and it is possible that the warnings may actually have been given prior to that date.

On 29 April AC was involved in a fight with another prisoner. The Medical Record notes that AC was assaulted, with no apparent injury sustained but it seems that AC was in fact the assailant. An adjudication hearing took place the following day at which AC admitted assaulting another prisoner in a cell, resulting in injuries to his face and head. The assault was considered sufficiently serious by the Governor hearing the case to refer the matter to the Independent Adjudicator, a District Judge who is able to impose additional days of imprisonment as a penalty. The initial Governor’s hearing on 30 April received a conduct report which noted that AC “has generally conformed to the regime and kept himself to himself. Never been a major problem for wing staff”.³¹

²⁹ P-NOMIS is the Prison-National Offender Management Information System

³⁰ P-NOMIS. Annex G

³¹ F256 Record of Adjudication Hearing. Charge number 270492. Annex H

After the incident AC was placed in the Care and Separation Unit (CSU) for one night until the initial adjudication by the prison Governor was held on 30 April. An Initial Segregation Safety Screen was completed which did not find any health care reasons against holding AC in segregation.³²

The independent adjudication took place a fortnight later on 14 May. By this time, AC had been moved from G Wing to A Wing where he was described in a conduct report as behaving well and complying with the wing regime, raising no cause for concern.³³ The Independent Adjudicator's record of the hearing noted that staff on the wing reported AC to be quiet, keeping himself to himself. The record also noted by way of mitigation that AC said, "It's about abuse and threats. Verbally threatened for months. Afraid.People calling me a grass, knowing my address, my sister's address. I'm an emotional wreck: I'm being broken. Can't get my proper medication. Shd be olanzapine. Blurred vision now. Fuzzy hearing. I've now been moved : on A Wing now. But it's worse."³⁴

The Independent Adjudicator imposed a sentence of 21 additional days imprisonment.

On 29 April, the day that AC was involved in the assault, the Mental Health Outreach Team was considering his case – some seven weeks after he had been assessed by Nurse C on 8 March and more than four weeks after he had asked to see a psychiatrist on 22 March. The Medical Record notes AC's "past history of self harm in context of his personality difficulties" and that Nurse C "had discharged him within week of assessment as" AC "does not suffer from enduring mental illness". The record then also notes that AC "was also assessed in the past and was deemed inappropriate for outreach input".³⁵

³² Ibid

³³ Ibid

³⁴ Ibid, page 3, section 14

³⁵ Medical Record Printout, 10 May 2010. Annex F

Chapter Six

30 April to 24 May

After the initial disciplinary hearing on 30 April following the 29 April assault, AC was moved from the Care and Separation Unit to A Wing. A Cell Sharing Risk Review raised his rating from medium to high.³⁶ Initially, he was in Cell 1-032 but moved cell after a court appearance on 7 May. From 7 to 10 May he was located in C Wing, returning to Cell 2-045 on A Wing from 10 May until 24 May.

AC missed a further appointment with the GP on 14 May.

On 18 May, AC's sister, LC, wrote a handwritten letter to Nurse N who worked in Health care, expressing great concern about her brother.³⁷ In her letter LC explained that AC had been taking olanzapine for the last five years, that this was stopped several weeks before and that AC "is now very close to a mental and psychotic breakdown, whereby he hears voices and has hallucinated. And he will become a DANGER TO OTHERS AROUND HIM and himself". LC's letter described how, when AC's olanzapine was stopped during a previous period in prison, he had been admitted to hospital before being put back on the anti-psychotic drug. LC asked that AC be assessed, put back on the medication and supervised taking it. "I visit [AC] several times every week and can see the signs that he has become seriously mentally ill, I've been his carer for 5 years throughout his mental illness and am aware of the signs of his deterioration". The P-NOMIS electronic record shows that LC visited AC on 6, 12, 14, 18 and 21 May.³⁸

AC's sister, LC, also mentioned that she had spoken to a prison officer who had arranged for AC to see a doctor on 17 May but that he had spent only two minutes with AC in his cell, deciding that he was assessing the wrong prisoner. In her letter LC said that there were two prisoners with the same surname on A Wing. The electronic record system NOMIS has been interrogated by the National Offender

³⁶ Cell Sharing Risk Review 30 April 2010. Annex C

³⁷ Letter from LC to Nurse N, 18 May 2010. Annex J

³⁸ P-NOMIS. Annex G

Management Service (NOMS) and there does not appear to be a record of a prisoner with the same surname on A Wing on 17 May 2010.

There is no reference to this appointment in the Medical Record although there is a missed appointment recorded for 18 May. On the following day, 19 May, AC was seen first by Nurse F from Substance Misuse and later by a doctor from that team. The Medical Record notes in capital letters, "NEEDS OLANZAPINE 15MG ON -- SAYS HE HAS BEEN ON THIS FOR LAST 3 YEARS. NEEDS TO BE CONFIRMED WITH GP BY HEALTHCARE."³⁹ This may suggest that the letter from AC's sister, LC, had been received and prompted a more active approach. The next day, 20 May, another GP at the prison, Dr G, spoke on the phone to AC's community-based GP, Dr E, who described AC's history, "not diagnosed with psychosis although was prescribed with olanzapine which he took on and off and appeared to have a calming effect. Was on citalopram at one stage".⁴⁰ Dr G asked Dr E to write to support AC's request to serve his sentence in Brixton. The Medical Record notes in capital letters, "NO CONTRAINDICATIONS FOR TRANSFER HERE EXPRESSED" Dr E was to fax "a written account of the details expressed in the above encounter", although AC's Medical Record had already been faxed to the prison from the GP surgery on 18 March and the community-based GP, Dr E, had sent a letter with the details "To Whom it May Concern" a month earlier on 23 April.⁴¹ After the telephone conversation on 20 May, Dr E faxed to Dr G this letter along with two others: one dated 26 June 2007 from a Consultant Psychiatrist to Dr E⁴² and the second a letter dated 30 January 2009 from Dr E to the North Lambeth Assessment and Treatment Team asking them to see AC as soon as possible "in view of his obvious ongoing psychotic features".⁴³

³⁹ Medical Record Printout, 19 May 2010. Annex F

⁴⁰ Medical Record Printout, 20 May 2010. Annex F

⁴¹ See page 30, final paragraph, regarding Letter from Dr E "To Whom it May Concern", dated 23 April 2010. Annex J

⁴² Letter to Dr E, a community-based GP, from Consultant Psychiatrist in the community Assessment and Treatment Team, 26 June 2007. Annex F

⁴³ Letter from Dr E, community-based GP, to Assessment and Treatment Team, 30 January 2009. Annex F

AC's behaviour on the wing was starting to cause concern. The Observation Book noted that on the evening of 20 May, AC had become abusive when told to unlock his cell flap, saying he would knock out staff and demanding to go to the Care and Separation Unit.⁴⁴

On receiving the faxed material the next day, 21 May, Dr G noted on the Medical Record, "To ask psychiatrists to assess re the use of olanzapine dosage and frequency".⁴⁵ On the same day, 21 May a nurse recorded AC's bizarre behaviour when he came for his methadone, discarding most of it in a bin and saying he has schizophrenia. A plan was recorded to refer to the Mental Health Outreach Team for comprehensive mental health assessment, review in clinic and discuss concern with the GP over the weekend.

A letter, dated 20 May 2010, also arrived from AC's solicitors, who had been informed by AC's sister, LC, of her serious concerns about AC's mental health, the lack of olanzapine and the need to supervise him taking it.⁴⁶ The contents of AC's solicitors' letter mirrored those in the letter from AC's sister. Dr J, a Consultant in Forensic Psychiatry, replied to the solicitors on 24 May, saying that a "psychiatric review will be arranged as soon as possible".⁴⁷

In the meantime AC's deterioration continued. On Saturday 22 May, another prisoner alleged that AC had assaulted him for no reason. AC was put behind his door and refused his lunch. Although the other prisoner had swelling around his eye, no disciplinary action was taken. Other prisoners on the landing made verbal threats to AC. Several broken broom handles were also found in AC's cell.⁴⁸

On the same day, 22 May, concerns were raised with Nurse K from the Primary Care Mental Health Team by SO L. Nurse K spoke to AC at the cell door, recording that "he was not very cooperative". She noted, "Did not maintain eye contact and kept

⁴⁴ A Wing Observation Book. Annex G

⁴⁵ Medical Record Printout, 21 May 2010. Annex F

⁴⁶ Letter from AC's solicitors to the Governor, HMP Brixton, 20 May 2010. Annex J

⁴⁷ Letter from Dr J to AC's solicitors, 24 May 2010. Annex J

⁴⁸ A Wing Observation Book. Annex G

muttering things under his breath. Appeared to be staring at the wall and did comment that he saw things that were not there and described seeing his dead English mother. He also kept asking to go to the block”.⁴⁹ Nurse K reported that AC’s cell was in “an abysmal state” and that he had said he was on olanzapine. Nurse K noted that she would discuss with Mental Health Outreach the following Monday. AC was recorded as denying any thoughts of suicide or self-harm but was “currently at risk of harm to others” and was “escorted by officers at all time due to his risk factors”.⁵⁰

An entry in the P-NOMIS electronic record system described AC’s behaviour as “up and down at the moment from hour to hour he can be very aggressive and rude and then act as if everything is fine. this evening he has put on his bell stating prisoners and staff have broke into his sister house when questioned on his comments stated ‘you lot just watch I know your all in on it’ 10 minutes later put on his bell asking kindly for a pen and help with canteen sheet behaviour and mood swings very unpredictable’⁵¹ The A Wing Observation Book notes that AC “needs urgent referral due to mood swings and change of behaviour”.⁵²

On the same day, AC refused his methadone and then asked for a reduction. His dose was reduced pending a review. AC refused again on the 23 May, signing a treatment refusal form.⁵³

⁴⁹ Medical Record Printout, 22 May 2010 entry by Nurse K. Annex F

⁵⁰ Ibid

⁵¹ P-NOMIS, entry created 22 May 2010. Annex G

⁵² A Wing Observation Book, 22 May 2010. Annex G

⁵³ Treatment Refusal Form. Annex F

Chapter Seven

24 May to June 4

On Monday 24 May AC was moved to B Wing and placed in Cell B3-016. Nurse C from the Mental Health Outreach Team saw AC once again. He noted “for the record” that AC “was assessed twice in the past” and that, following discussion in the Outreach meeting, he “was judged inappropriate for outreach caseload as he could be managed by the G.P/primary care” as had been the case in the community.⁵⁴

Nurse C assessed AC as tired, with a good insight into his mental health needs and without any bizarre speech. AC said that he had been prescribed olanzapine in the community by his GP; that his auditory hallucinations are “same level”; that he is happy to take medication and that he continues with substance misuse [presumably meaning with the Substance Misuse Team]. Nurse C concluded that AC “doesn’t appear to suffer from enduring mental health symptoms” and denies any ideas, thoughts or plans about deliberate self-harm or suicide, noting that AC was in a single cell “as [he] had physical outbursts with other prisoners on the other wing”. Nurse C did say he will liaise with doctors for prescription of the olanzapine. He recorded that he spoke with the prison-based GP, Dr G, who felt that the prescription needs to be undertaken by the psychiatrist as the community GP was not concrete about the diagnosis of schizophrenia/psychosis.⁵⁵

Nurse C also spoke to Dr J, the Consultant in Forensic Psychiatry, who said the case should be discussed at the team meeting in three days’ time, on Thursday 27 May, as there was no concrete evidence of his diagnosis. Dr J said he would reply to the solicitors’ letter and AC was placed on “pending cases caseload”⁵⁶ with a plan to arrange an appointment with another psychiatrist, Dr M. Dr J informed us that Nurse C’s discussion with him took place “in the corridor” and that he, Dr J, advised that the GP should prescribe medication because they had seen the patient and had a duty

⁵⁴ Medical Record Printout, 24 May 2010, entry by Nurse C. Annex F

⁵⁵ Ibid

⁵⁶ Ibid

of care towards him.⁵⁷ Nurse C also recorded that he tried to contact AC's sister, LC.

Following discussion at the Mental Health Outreach meeting on Thursday 27 May, an appointment was booked for AC to see Dr M on the following Wednesday, 2 June, with AC remaining on "pending cases" until then.⁵⁸ Dr J informed us that "the pending caseload was one in which individuals were offered care coordination pending case formulation and diagnostic clarity, often used in cases where there was some diagnostic uncertainty."⁵⁹

On the afternoon of 27 May, the day of the Outreach meeting, AC was involved in an attempted assault of another prisoner who came to his cell door. The two prisoners were separated by officers. An entry in the B Wing Observation Book by Officer W notes that "I believe [AC] has mental health issues, he refuses to interact with anybody and is always angry and agitated. I overheard a few prisoners saying that he should be relocated to another wing as he has upset many other prisoners."⁶⁰ A further entry on 27 May, by another officer, notes that AC "has accrued debts on other wings (which is why he is on B Wing). He is probably using us to separate him."⁶¹

AC was charged with a disciplinary offence and two days later, on 29 May, having been found fit for adjudication he was sentenced to loss of association, the removal of his television and forfeiture of his facility to use cash to make purchases, all for 14 days.⁶²

⁵⁷ Email from Dr J to Rob Allen, 17 February 2015, commenting on behalf of the healthcare providers at Brixton on the Draft Report. Annex Q

⁵⁸ Medical Record Printout, 28 May 2010 entry by Nurse C. Annex F

⁵⁹ Email from Dr J to Rob Allen, 17 February 2015. Annex Q

⁶⁰ B Wing Observation Book, 27 May 2010 entry by Officer W. Annex G

⁶¹ B Wing Observation Book, 27 May 2010

⁶² F256 Record of Adjudication Hearing. Charge number 285547. Annex H

On 1 June, AC was moved to a different cell, B 2-032. In the evening, AC “started banging on his door and then smashed his television for no apparent reason.” He was shouting, “Fucking racist British pig”.⁶³ He was made to clean the glass out of his cell and stated he was “stressed”.⁶⁴

Two days later, 3 June, he was sentenced to a further 14 days loss of privileges for using threatening, abusive or insulting words or behaviour.⁶⁵ AC pleaded guilty although he is recorded as saying at the hearing that the abusive words were shouted out of the window rather than at an officer.⁶⁶ No conduct report was compiled for the adjudication hearing. A segregation safety screen was prepared, presumably for the period he was held there waiting for the adjudication. This did not identify any mental health problems and he was assessed as fit for adjudication and segregation.⁶⁷

In the two days between the assault on 1 June and the adjudication on 3 June, AC had received a Red Entry on the P-NOMIS recording system for being rude and abusive to another prisoner and not returning to his own landing.⁶⁸ He was given an Incentives and Earned Privileges (IEP) warning for this on 2 June. IEP is the system for granting privileges to prisoners, subject to their behaviour.

On 2 June AC had failed to attend his appointment with Dr M, a psychiatrist in the Mental Health Outreach Team. It seems to be the case that AC was subject to controlled unlock following the incidents of violence and abuse. Staff did not unlock his cell to allow him to attend the appointment. Following his failure to attend, Dr M noted that Outreach nurses were to monitor AC “as per his zoning” and let Dr M know of any concerns.⁶⁹

⁶³ P-NOMIS, entry on 1 June 2010. Annex E

⁶⁴ B Wing Observation Book, 1 June 2010, entry at 22.15. Annex G

⁶⁵ F256 Record of Adjudication Hearing. Charge number 286740. Annex H

⁶⁶ Ibid

⁶⁷ Medical Record Printout, 3 June 2010. Annex F

⁶⁸ P-NOMIS. Annex G

⁶⁹ Medical Record Printout, 2 June 2010, entry by Dr M. Annex F

On 3 June AC made a large number calls on his cell bell (on ten occasions between 12.12 and 18.54 hours).

On 3 June, AC was also involved in another unprovoked attack on a prisoner. A Security Intelligence Report (SIR) was submitted and the Wing Observation Book notes that "Perp Plan updated" – a reference to a Perpetrator Plan which was a system for managing violent behaviour by prisoners.

A further entry in the B Wing Observation Book notes that AC "cannot go to A or G Wing, attempts to move him to C Wing are a slow process. Spoke with Governor AA who is looking into an SIR from previous week involving a similar incident. No answer as yet (16.40)."⁷⁰

⁷⁰ B Wing Observation Book, 3 June 2010, 16.40. Annex G

Chapter Eight

4 June, the Day of the Incident of life-threatening Self-Harm

The Duty Governor Handover Checklist on the morning of Friday 4 June includes an entry at 7.55 a.m. that AC is “to go to G Wing.”⁷¹

AC pressed his cell bell at 08.07, 11.45, 12.16 and 12.29.⁷²

Officer O took AC his lunch in his cell at about 12.25. AC told him that he wanted to talk to the SO about getting off the wing. Officer O talked to SO P who was busy with arrangements for Muslim prayers and said she would go and see AC afterwards. When Officer O returned to the cell, AC said “I’m gonna do something stupid” and was holding sheets.⁷³ Officer O rushed back to SO P and told her that AC had made a noose. They went straight back to the cell but could not open the door because AC had made a barricade by placing his cabinet between the bed and the cell door.

A noose had been tied around the window but AC was initially standing by the door or lying on the bed. After this point the precise order of events is not absolutely clear from the evidence.

At about 12.40 SO P called for assistance; she says she did so over the radio but there is no record of a radio call at this stage. Officer O and Senior Officer P told the internal investigation that a call was made. Senior Officer P told us that she made a call for staff assistance. Officer O told us that a call was made for Oscar 1 to get there although in his statement made on the day Officer W said he was told to get Oscar by SO P.

⁷¹ Duty Governor Handover Checklist, 4 June 2010. Annex G

⁷² Cell bell record. Annex G

⁷³ Transcript of interview with Officer O, page 11. Annex C

Other staff arrived rapidly on the scene. These included Officers R, S, T, U and W and Governor V. Senior Officer Q was on the scene and the Governing Governor Z was also present.

SO P told AC he would not be able to move from the wing. At this point AC appears to have moved to the back of the cell tied the noose around his neck while standing on the pipes at the back of the cell or the frame of the bed.

It was decided immediately to try to enter the cell. Efforts were made to kick the door in order to break the cabinet but this did not work. Officer W fetched the toolkit from the wing office which could be used to remove the screws from the heel plate on the cell door so that it could be opened outwards.

In the meantime staff were talking to AC through the flap on the cell door. Officer T recalls that AC kept saying, "I told them I have to get out of the cell".⁷⁴ AC said that he had told an officer earlier that he had to get out but that this had been refused. SO P told us that Governor V then talked to him and told him that he could move.

It is not clear exactly at what point AC started hanging. The internal investigation received evidence that he placed the noose around his neck and stood and then jumped off the pipe. Officer O told us "I don't think ... In my opinion, I don't think he was actually meaning to do it. I think he was just trying to get a point across. But, I don't know why or how he was ... I think his feet must have just slipped. But that's my personal opinion."⁷⁵

The staff working to remove the heel plate found that one of the screws was jammed. It was impossible to apply the tool to the screw. Several staff tried and it was decided to call a locksmith from the works department who would have a wider range of tools. SO BA said in her witness statement made on the day that she called Carillion [the works department].⁷⁶

⁷⁴ Note of telephone interview with Officer T, page 1. Annex C

⁷⁵ Interview with Officer O, page 18. Annex C

⁷⁶ At Annex K

Mr X was having lunch when his boss told him to go to B Wing to deal with a barricade incident. He told us that as he was walking over he was told to hurry up as it was a Code 1 – he had not realised the gravity of the situation.

When he arrived at AC's cell, he found that the screw was blocked with toothpaste or paper but was rock hard. He used a pick, a screwdriver and a hammer to clean out the area before removing the screw. He estimates the time from receiving the call to opening the door was between six and eight minutes.

Once the door was opened, at 12.52 staff rushed in. Officer T, who had been trying to talk to AC, and Officer R supported AC's body while Officers O and S cut the noose and removed it over AC's head. According to Officer R, "they had a bit of trouble cutting it. And I can remember 'cause I think it was Mr O was on one of his side and it might ... I don't know if it had cut right into him and that, but they had to jig about with it to get it off. And so I had to prop him up a bit longer than what I thought I had to".⁷⁷

AC was laid on the bed. He was not breathing.

It is not clear if there were medical staff present when the door was opened. SO BA said in the statement she made on the day that she had called for Hotel 6 [the emergency response nurse] to attend and that when Hotel 6 arrived she [SO BA] also called for a Code 1 and asked the Control Room for an ambulance. The Code 1 was noted at 12.55.

Governor Z said Hotel 6 was already in attendance when the door was opened and Officer W told us that "Obviously, for precaution, someone must have called the nurse as well. So there was the nurse on stand-by."⁷⁸ This was probably Hotel 6. He was probably the only medical staff member on the scene until after the door was opened.

⁷⁷ Interview with Officer R, page 5. Annex C

⁷⁸ Interview with Officer W, page 11. Annex C

Another nurse, Nurse BE, made a statement that she received a phone call from Hotel 6 around 12.55 to request the Code 1 bag as a prisoner had barricaded his cell, “just in case”.⁷⁹ Nurse BE said that around one minute later Code 1 came over the radio. By the time she arrived with the equipment, the cell door was already opened and staff were working on AC. Officer S told us it was “minutes – a matter of minutes.” “ ‘Cause they had to go and get the Ambu bag or whatever to do resusc...”⁸⁰

In the meantime Officer T applied cardiopulmonary resuscitation (CPR) for several minutes, with the assistance of Hotel 6. At 12.59 AC started breathing and at this point health care staff took over. Officer T told us that one of the oxygen tanks was faulty and that the face mask which was initially applied was not the correct size. Officer S also said that “they put one of those bubble bag things which – one of them, when they squeezed it, popped, so they had to get another one, to try and get some oxygen into him.”⁸¹

At 12.59 Dr G, a prison-based GP, arrived on the scene. At 13.02 the ambulance arrived at the prison, with paramedics at the cell by 13.09. They called for an air ambulance which arrived at 13.22. The paramedics from the air ambulance had arrived at the cell by 13.30. AC was moved from his cell ten minutes later and, after a period of preparation, was taken to the ambulance at 14.02. AC was taken to King’s College Hospital.

An ACCT was opened and an alert to that effect was entered onto the Contact Logs section of the P-NOMIS electronic record system at 15.15.⁸² AC’s sister, LC, has questioned whether the ACCT might in fact have been opened earlier in the day. She raised this question because the way the summary contact log is presented gives the time of this alert as 00.00, i.e. midnight, and therefore lists it earlier than an entry on the log (for negative behaviour by AC) which is timed at 11.05. It has however been explained by NOMS that all alerts on P-NOMIS are timed at 00.00,

⁷⁹ Witness statement of Nurse BE. Annex K

⁸⁰ Interview with Officer S, page 10. Annex C

⁸¹ Ibid

⁸² The Contact Logs are on the 7th to 14th pages within the P-NOMIS print-out. The specific note recording the opening of the ACCT is on the 8th of these pages. P-NOMIS. Annex G.

irrespective of the time at which they are actually put on the system. This is confusing, but the detailed record in the Case Notes section of the relevant log makes it clear that the ACCT was made active at 15.15 by SO Q.

Part Three. Issues Examined in the Investigation

Chapter Nine

Assessment and Diagnosis of AC's Health Problems

The Prison Service has a standard “to provide prisoners with access to the same range and quality of services as the general public receives from the National Health Service (NHS).”⁸³ The overarching questions which we have considered are whether AC received the medical care which he would have received in the community, and whether the care was of a good enough standard. We consider these questions in relation to when AC was first received into Brixton Prison, throughout his three-month stay in the prison and in particular when his mental health deteriorated markedly during the middle of May 2010.

Prison Service establishments are required to provide services for the observation, assessment, treatment and care of prisoners with mental health care needs. Prisoners should be treated by a multi-disciplinary team in line with the good practice laid out in the Code of Practice on the operation of the Mental Health Act and standards set out in the National Service Framework (NSF) for Mental Health. The NSF was replaced in 2009 by the document New Horizons – A Shared Vision for Mental Health, published by HM Government.⁸⁴

It is convenient to consider the questions relating to the care received by AC, first in relation to assessment and diagnosis, and second in relation to treatment.

⁸³ Prison Service Performance Standards Manual no 22. Health Services for Prisoners, page 1. Annex L

⁸⁴ New Horizons – A Shared Vision for Mental Health, published by HM Government, is at: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_109708.pdf. Extract (page 61) at Annex L

Assessment and Diagnosis

When AC was received into Brixton in March 2010, the initial assessments were timely. He was seen by a GP on the day of his reception and referred appropriately to the Substance Misuse Team, Blood borne Virus team and the Mental Health Outreach Team for specific further assessments.

The specialist teams responded quickly to the referrals, seeing AC over the next four days. The Lambeth PCT report found that AC received a thorough reception and secondary health screen when he initially arrived at Brixton.

The Mental Health Outreach Team assessment on 8 March is fully recorded and identifies AC's history and contact with services in the community. Nurse C, who undertook this assessment, had previously seen AC seven months earlier when a subsequent discussion at the Outreach team meeting had identified AC's primary problem as substance misuse and Nurse C had been tasked with liaison with the Substance Misuse Team to ensure follow-up.

The SLAM report found that AC received a good mental state examination on 8 March. The Care UK report found, however, that the nurse conducting the assessment "may have been persuaded in their judgement by their assessment and recommendations regarding the same patient when previously serving time in the HMP establishment".⁸⁵ It also found that "the response to the GP referrer was not complete or timely"⁸⁶, not answering the GP's question with regard to prescriptions and treatment.

On 8 March 2010, Nurse C noted a plan for the case "To be discussed in outreach meeting."⁸⁷ The case was not however discussed until 29 April, and the outcome not recorded until 10 May.

⁸⁵ Care UK report, page 12. Annex D

⁸⁶ Ibid

⁸⁷ Medical Record Printout, 8 March 2010, entry by Nurse C

It is not clear why there was such a long delay. Dr J, the Consultant Psychiatrist, told us that “The delay in the Mental Health Outreach team discussing the case between the 8th March assessment and the 29th April was not in accordance with policy. The case should have been discussed at a weekly meeting.”⁸⁸ Dr J further informed us that “Outreach team meetings happened weekly and were attended by medical staff. It was standard team procedure for all new cases to be discussed at the next available team meeting and CPNs held responsibility for ensuring that this took place”.⁸⁹ Nurse C suggested that perhaps doctors were not available and therefore meetings were cancelled. Nurse D said that “the only reason probably it wasn’t discussed sooner because he might have been seen as a low risk”.⁹⁰ Dr J told us that “all cases were discussed at the next meeting, regardless of the level of assessed risk. Meetings were cancelled very infrequently – if the Consultant was not present (e.g. annual or study leave) a junior doctor was generally present to lead the meeting”.⁹¹

The Clinical Review recommends that the Mental Health Outreach team should have minimum timescales between assessment and review. We agree.

Finding One: **The seven week delay between AC’s assessment by the Mental Health Outreach nurse on 8 March 2010 and the case discussion by the Team on 29 April 2010 was unacceptably long.**

Recommendation A: **The Mental Health Outreach Team should review any assessment undertaken by a team member within a maximum period of one week.**

⁸⁸ Note of telephone interview with Dr J, para 2. Annex C

⁸⁹ Email from Dr J to Rob Allen, 17 February 2015. Annex Q

⁹⁰ Interview with Nurse D, page 4. Annex C

⁹¹ Email from Dr J to Rob Allen, 17 February 2015. Annex Q

The meeting was eventually held on 29 April, but the note of the meeting was not entered onto the Medical Record until 10 May. Given the importance of the Medical Record as a tool for communication between the various medical staff involved in the care of AC, this delay is unacceptable. When the note was entered, it did not, as the Care UK report found, “include any advice relating to the GP’s questions on the referral form”.⁹²

Finding Two: **The delay between the Mental Health Outreach meeting on 29 April and its entry on 10 May was too long and the note did not address the issues raised in the referral.**

Recommendation B: **The Medical Record should be properly updated within 24 hours of any action taken or decisions made.**

The Medical Record notes that Nurse C had discharged AC within a week of assessment as “AC does not suffer from severe enduring mental illness”⁹³. There is no earlier record of AC having been discharged. Indeed, it is not exactly clear what discharge means in this context since AC had not been taken on to the caseload of the Mental Health Outreach Team. Nurse C told us that “We would not have discharged anyone unless that meeting has happened. So, I think there is a problem whether they had no admin maybe at the time to actually do the documentation, or the doctor did not have time, so I basically put a note on the system to that effect.”⁹⁴ There is no other evidence of any involvement by a doctor in the decision to discharge AC. Moreover, there is no “note on the system” – only a report some two months after the initial assessment that AC had been discharged. There is a section on the form completed by Dr B referring AC to the Mental Health Outreach Team which is headed ‘Action plan by outreach team’. This section has been left blank.⁹⁵ There are a number of possible explanations for what happened. In respect of the

⁹² Care UK report, page 13. Annex D

⁹³ Medical Record Printout, 10 May 2010. Annex F

⁹⁴ Interview with Nurse C, page 5. Annex C

⁹⁵ HMP Brixton Mental Health Outreach Team. Referral form. Dated 6 March 2010. Annex F

“note on the system”, it is possible that Nurse C was thinking about a previous occasion in 2009 when, following a meeting of the Mental Health Outreach Team, a letter was sent to Primary Care explaining that AC was not being taken onto the caseload.⁹⁶ According to Dr J, “it is possible that the team meeting did take place” at which the decision to discharge was made on this occasion “but that the outcome was not recorded if there was nobody to take minutes of the meeting”.⁹⁷ There is no doubt that such a meeting should have been held and its decisions properly recorded and communicated to those that needed to know. According to Dr J, “Nurses alone are not able to discharge patients from the caseload. It was team procedure for any discharge decisions to be made following multi-disciplinary discussion and fully recorded at the team meeting”.⁹⁸

Finding Three: **It is important that decisions to discharge patients from the Mental Health Outreach Team are not taken by a nurse alone. When such a decision is taken it should be recorded immediately and communicated to the person who referred the case, in this instance the GP.**

A question also arises about the status which AC had in respect of the Mental Health Outreach Team during the period between the assessment and a decision about whether to accept him onto the caseload. It is not clear what status AC had in the week between the assessment on 8 March and his reported discharge from the caseload a week later, nor between the assessment made by Nurse D on 22 March and the discussion by the team on 29 April.

As far as the first of these periods is concerned, Nurse C described a pending status. “It’s on pending, so that means he has to be managed by the relevant team, i.e. in that case would be the Substance Misuse and the GP as well. Because everybody is under the GP care in prison.”⁹⁹

⁹⁶ Letter from Outreach to Primary care undated. Annex F. (Referred to in Medical Record Printout, 20 August 2009. Annex F)

⁹⁷ Email from Dr J to Rob Allen, 17 February 2015. Annex Q

⁹⁸ Ibid

⁹⁹ Interview with Nurse C, page 6. Annex C

The term “pending” appears to have two different meanings, however. After Nurse C assessed AC on 24 May, he noted that AC was placed on pending cases caseload until the case was discussed at the Mental Health Outreach meeting later in the week; and at that meeting it is noted on 28 May that AC remains on pending cases until his appointment with the psychiatrist, Dr M, booked for 2 June. When AC did not attend the appointment, Dr M noted “Outreach CPN [Community Psychiatric Nurse] to monitor him as per his zoning and let me know if any concern”.¹⁰⁰

This is the first reference in the Medical Record to “zoning”, which we were told is a prioritisation system for allocating the resources of the Mental Health Outreach Team based on risk. Patients in the red zone are seen every day, in the amber zone every week and in the green zone every two weeks. Nurse C told us that only cases on the caseload are prioritised in this way. The implication is that after 24 May AC’s status as a pending case meant that he was proactively monitored as per the zoning arrangement, whereas after 8 March he was a pending case but not subject to a zoning prioritisation. Dr J informed us that “all patients on the pending caseload were managed as if they had been accepted onto the caseload” and that “all cases were subject to zoning.”¹⁰¹ At the least, it seems that the policy on when a case should be subject to zoning was not clear.

In AC’s case, the zoning may not have amounted to much. Nurse C told us that after 24 May AC would have been on an amber priority but was not in fact seen in the ten days until his appointment with Dr M – an appointment that he did not attend. The Clinical Review for this investigation finds that amber zoning “should have triggered at least weekly contact from the outreach team.” ... “this would have allowed for a further review to have taken place prior to his appointment with the psychiatrist. This did not happen”.¹⁰²

¹⁰⁰ Medical Record Printout, 2 June 2010, entry by Dr M. Annex F

¹⁰¹ Email from Dr J to Rob Allen, 17 February 2015. Annex Q

¹⁰² Clinical Review by Professor Jonathan Warren, para 4.6. Annex A

Dr J told us that “Zoning should be immediate and then ratified by the meeting”¹⁰³ and that it was regularly reviewed by the team leader and clinical lead as part of a compliance process.¹⁰⁴ But the system for dealing with pending cases was not sufficiently clear in practice and not fully applied in AC’s case. The Clinical Review recommends that SLaM has a system of monitoring and auditing compliance with the zoning protocol. We agree.

Recommendation C: **In the period between an assessment by the Mental Health Outreach Team and a decision about whether to accept a prisoner on to the caseload, a pending case should be subject to a provisional zoning priority. A system of monitoring and auditing compliance with the zoning protocol should be in place.**

A further weakness in the process was that the assessments undertaken on AC while he was in Brixton do not appear to have taken account of the full range of information available about him. The medical records from the Community GP practice were requested in a timely fashion on 8 March and appear to have been faxed over but then misplaced. Mr H told us that “It was not routine to request GP records or notes for every single prisoner that came through the door.”¹⁰⁵ But for prisoners with drug addiction problems they were always requested. The notes were requested again on 18 March. This suggests that the decision to discharge AC from the Mental Health Outreach Team’s pending caseload may have been taken without seeing the notes. The Lambeth PCT report found that there was “no evidence to support who the notes were given to when they arrived or if anyone read them”¹⁰⁶ The SLaM report found that “Primary Care (Care UK) and Substance Misuse (SLaM) do not read all the medical notes as a matter of routine.”¹⁰⁷ Moreover, there was a separate record-keeping system in operation called ePJS, the Electronic Patient

¹⁰³ Note of telephone interview with Dr J, para. 3. Annex C
¹⁰⁴ Email from Dr J to Rob Allen, 17 February 2015. Annex Q
¹⁰⁵ Interview with Mr H, page 29. Annex C
¹⁰⁶ The Lambeth PCT report, page 18. Annex D
¹⁰⁷ The SLaM report, page 4. Annex D

Journey System. The SlaM report found that the only staff who had access to ePJS were the Mental Health Outreach Team and recommended that consideration be given to improving access to ePJS for the whole prison.

It is not clear that AC's medical records had been consulted in the two and a half months since his arrival at Brixton. Dr J's response to the letter from AC's solicitors on 24 May asks the solicitors if they "could forward over any background information regarding your client's history of mental health problems and ask his sister to liaise directly with the mental health outreach team".¹⁰⁸ While this may be a standard kind of request made in such letters, it could also suggest that background information had not hitherto been considered. AC's sister, LC, takes this view.

Policy on mental health is based on the principle of thorough assessment.¹⁰⁹ It is questionable in AC's case whether the assessment was sufficiently thorough.

Finding Four: **While AC's notes arrived reasonably quickly from the community GP practice, it is not clear the extent to which they were used to inform his assessment and diagnosis.**

Recommendation D: **Every effort should be made to gain access to a prisoner's medical records from his GP or local hospital within 24 hours of reception into prison.**

The question of assessment was complicated in AC's case by the fact that he suffered from both addiction and mental health problems. Such dual diagnosis cases are not uncommon in a prison setting or in the community. The Substance Misuse Team developed a reasonable care plan for AC. However, there was limited communication with Mental Health Outreach until mid-May. During March and April, AC reportedly used heroin and failed to take his methadone on several occasions. Yet there was no input from the Substance Misuse Team into the Mental Health Outreach Meeting on 29 April. When AC's mental health deteriorated during May,

¹⁰⁸ Letter from Dr J, Consultant in Forensic Psychiatry, to AC's solicitors, 24 May 2010. Annex J

¹⁰⁹ New Horizons – A Shared Vision for Mental Health, page 61. Annex L

on 21st of that month he was referred for a comprehensive mental health assessment after showing bizarre behaviour when he came to collect his methadone. We were told by Nurse F that the substance misuse worker who made the referral had some responsibility for dual diagnosis cases¹¹⁰. Neither this worker, nor anyone from the Substance Misuse Team, took part in the meeting to discuss AC three days later.

Finding Five: **Although there were mechanisms in place for joint discussions about cases such as AC, coordination and communication between the Substance Misuse Team and the Mental Health Outreach Team could have been stronger in respect of AC's assessment, treatment and care.**

Recommendation E: **In a case where a prisoner has both substance misuse and mental health problems – so-called dual diagnosis – a joint assessment by a mental health and a substance misuse specialist should be carried out.**

Non-medical information seems to have played a very limited part in assessments of AC. An OASys assessment had been carried out in 2007. This included a reference to how AC had previously demonstrated psychotic behaviour whilst in custody. There is no reference to this being consulted at all in 2010. Nor was information about AC's behaviour during his current period in prison fully considered in the assessments. There is one reference in his Medical Record to AC being seen in the Care and Separation Unit (CSU), as follows: "was assaulted on assessment no apparent injury sustained".¹¹¹ In fact, the entry is misleading. AC had committed a serious assault which led to a sentence of 21 additional days. The report of the

¹¹⁰ Interview with Nurse F, page 16. Annex C

¹¹¹ Medical Record Printout, 29 April 2010. Annex F

adjudication hearing notes that on 14 May AC claimed in mitigation, “I’m an emotional wreck: I’m being broken. Can’t get my proper medication.”¹¹² AC was involved in further assaults on 22 and 27 May and on 1 June. He was moved to a different wing on three occasions, on 15 March, 30 April and 24 May. Wing Observation Books include a reference to AC threatening to knock out staff and demanding to go to the Care and Separation Unit.¹¹³ Yet none of these items of information were pieced together as a part of an overall assessment of AC’s health and wellbeing while in prison.

The documentation and our interviews make it clear that AC was not properly diagnosed at any point while in Brixton. He was accepted onto the caseload of the Mental Health Outreach Team as a pending case only after his mental health had deteriorated markedly in the middle of May. He was never seen by a psychiatrist from that team (although he was seen by a psychiatrist from the Substance Misuse Team).

The Head of Health Care, Mr H, told us that he would have expected AC to have been taken onto the caseload after the first assessment in March. Given the medication that AC was taking, the decision to refer back to the GP was “the wrong thing to do”.¹¹⁴ The question of responsibility for AC’s health care, and in particular for decisions about prescribing, is discussed in the following chapter.

¹¹² F256 Record of Adjudication Hearing, Charge number 270492; in Section 14. Record of Hearing. Annex H

¹¹³ A Wing Observation Book, 20 May 2010. Annex G

¹¹⁴ Interview with Mr H, page 24. Annex C

Chapter Ten

Treatment and care

As described in Chapter Two, the organisation of health care in Brixton in 2010 was fragmented; a tripartite system existed in which Care UK had overall responsibility for health care and provided primary care, and in which SLaM provided secondary mental health and substance misuse services through two separate teams. The SLaM report found it to be “a highly complex system of healthcare provision which contributes to the communication problems”.

The demands placed upon the system were heavy at Brixton in 2010. Dr J told us that during 2010 Brixton was full of morbidity, a difficult place where the Health Care Centre – for the most serious cases that required in-patient treatment – was almost always full.¹¹⁵

AC’s experience of treatment and care by the health care services raises three main, inter-related issues, as detailed below.

- i. The first issue relates to the questions of:
 - (a) who within the prison health care setting should have been responsible for prescribing anti-psychotic medication;
 - and
 - (b) how the three branches of health care communicated about this.
- ii. The second issue relates to the very large number of occasions on which AC did not attend health care appointments.

¹¹⁵ Note of telephone interview with Dr J, Consultant in Forensic Psychiatry, para 1. Annex C

- iii. A further, third, issue relates to communication between health care staff and other staff at Brixton who had day-to-day contact with AC. This is discussed in Chapter Eleven.

i) Responsibility for Prescribing

A prison-based GP, Dr B, initially prescribed the anti-psychotic olanzapine and the anti-depressant citalopram for seven days when AC arrived in Brixton on 6 March. Within the Prescription and Administration Record Chart for AC, the Not in Possession Prescriptions sheet, which lists medication which is given out to a prisoner, notes with regard to these two entries, “PENDING CONFIRMATION from GP/SMT”, presumably a reference to the community-based GP and the Substance Misuse Team.¹¹⁶ The olanzapine prescription was continued by a prison GP, Dr G, on 13 March for three days with the Not in Possession Prescriptions sheet noting “PENDING CONFIRMATION BY PSYCHIATRY”.¹¹⁷ No review date is entered on the sheet in relation to that entry. After this prescription for olanzapine expired, AC did not receive any further olanzapine although there were further prescriptions for citalopram.

The decision not to continue the prescription of olanzapine was not taken as part of a plan of treatment for AC. The Clinical Review for this investigation rightly notes that AC told numerous doctors and nurses that he required olanzapine.¹¹⁸ AC’s sister, LC, and his solicitors let the prison know that he required it and the medical records showed that he had been prescribed it in the community. These factors do not in themselves mean that AC should have been prescribed the drug. It is possible that a doctor at Brixton could have taken a positive decision on clinical grounds that the medication was no longer required, for example on the grounds that his concordance with the drug (the extent to which he actually took the prescription) had been erratic in the past. This is not, however, what happened in AC’s case. The decision

¹¹⁶ Prescription and Administration Record Chart, on the Not in Possession Prescription sheet, two entries on 6 March 2010. Annex F

¹¹⁷ Annex F

¹¹⁸ Clinical Review by Professor Jonathan Warren: page 8, para 3.14; page 9, para 3.23; page 9, para 3.27; page 12, para 4.9 and page 13, para 4.6. Annex A

not to prescribe happened by default because practitioners within the health care system did not agree who should take responsibility for deciding to prescribe the medication and indeed to coordinate the overall care of AC.

The note of the assessment made by Nurse C from the Mental Health Outreach Team on 8 March records AC “Currently taking px [prescribed] meds from prison G.P: olanzapine 15 mg (nocte) [at night] and citalopram 10 mg” and the plan states “is happy to continue medication which he is concordant while in prison”.¹¹⁹ The plan continues, “He would be better look after by primary care/G.P and substance misuse as his symptoms seems mild and not severe”.¹²⁰ The ratification of this decision on 29 April made no reference to medication, possibly because the Mental Health Outreach Team thought that his medication had been continued by the GP. Dr J, the Consultant Psychiatrist in the Mental Health Outreach Team, informed us that as no psychiatrist from that team had seen AC, they would not have been able to prescribe for him. In his view, “the decision made by a GP to discontinue his medication had serious consequences. Had a direct communication been made to psychiatrists (email, phone call or visit), it would have been possible to arrange to review his medication”.¹²¹

In fact, AC did not attend a GP clinic between 13 March and 21 May. On 21 May, by which time AC’s mental health was seriously deteriorating, Dr G, a prison-based GP who had received a fax dated 20 May from Dr E, the community-based GP, commented, “To ask psychiatrists to assess re the use of olanzapine dosage and frequency.”¹²² Dr G told the investigation undertaken for Lambeth PCT that “patients on olanzapine. Especially on such a potentially high dose, would need to be seen by the psychiatrist for the assessment and prescription”.¹²³ The 20 May fax that Dr G had received from Dr E had contained copies of letters, including a letter from Dr E, a community-based GP, dated 23 April, in which he had mentioned an

¹¹⁹ Medical Record Printout, 8 March 2010, entry by Nurse C. Annex F

¹²⁰ Ibid

¹²¹ Email from Dr J to Rob Allen, 17 February 2015. Annex Q

¹²² Medical Record Printout, 21 May 2010, entry by Dr G

¹²³ The Lambeth PCT report, page 19, paragraph 4. Annex D

olanzapine dosage of “50mgs prn [to take as and when required]”¹²⁴; “50mgs prn” is almost certainly a typographical error since the true dose he had been taking was 15 mgs.

There was an earlier opportunity for a prison-based GP to make a request for the psychiatrists to review AC’s need for medication. On 26 March Dr B, a prison-based GP who had seen AC on 6th March on his reception into the prison and prescribed the olanzapine, saw AC again, although not in a GP clinic. The problem is noted to be drug dependence and AC’s dose of methadone was reviewed and raised. Other medication is not mentioned, despite the doctor knowing that AC was a dual diagnosis patient.

Despite numerous missed appointments, AC did see a psychiatrist in Substance Misuse on 19 April. While the psychiatrist noted that AC was not suicidal, and was waiting for hepatitis results, nothing is mentioned about anti-psychotic medication.

As for the likely consequences of AC stopping taking anti-psychotic medication, his medical notes include a letter to his community-based GP from a community-based Consultant Psychiatrist following an assessment in June 2007.¹²⁵ This letter states that AC “had a period when he stopped the Olanzapine in prison and felt noticeably different. He felt more tense and with a great feeling of pressure and described seeing little figures which he thought were ‘driving me crazy’”.¹²⁶

¹²⁴ Letter from Dr E, community-based GP, “To Whom it May Concern” at HMP Brixton, dated 23 April 2010. Annex F

¹²⁵ Letter to Dr E, a community-based GP, from Consultant Psychiatrist in the community Assessment and Treatment Team, 26 June 2007. Annex F

¹²⁶ Ibid, page 2

Finding Six: AC's prescription for olanzapine should not have been stopped in the middle of March. The Mental Health Outreach Team should have made it clear to the GP that referred AC that their decision not to accept him on the caseload meant that he would not be prescribed any medication by them; and the GP should have asked the Mental Health Outreach Team to review AC's medication.

Recommendation F: Drug Dependence Reviews of Dual Diagnosis Patients should consider the range of medication prescribed to a patient.

Having been discharged from the Mental Health Outreach Team shortly after his arrival at Brixton in early March, the Primary Care Mental Health Team might have provided some support to AC. They did not, however, receive a referral until 21 and 22 May when on two separate occasions they were asked to see him by concerned discipline staff. Before that they had not received a referral. According to Dr J, the Primary Mental Health Care Team would not accept a referral in this case, because of AC's substance misuse. "It is likely that no referral was made because the CPN knew from experience that the answer would be no. This was a serious service gap."¹²⁷

Finding Seven: When AC was discharged from Mental Health Outreach in March or when this was ratified on 29 April, a referral should have been made to the Primary Care Mental Health Team so that AC could have been supported by them. The PCMH Team should in appropriate cases offer to support to patients with substance misuse comorbidity.

¹²⁷ Email from Dr J to Rob Allen, 17 February 2015. Annex Q

The Primary Care Mental Health Team were contacted on 19 April by an Assistant Psychologist, Ms BD, who was AC's PPO Supervisor¹²⁸, after AC asked if he could be referred to mental health services whilst in custody. A member of the team replied that "considering that he is on a methadone maintenance we would normally expect Substance Misuse Dual Diagnosis worker to support him".¹²⁹ It is not clear whether Ms BD, the PPO Supervisor, contacted the Substance Misuse Team to establish whether they were in fact supporting him. In the view of Dr J, the Consultant Psychiatrist in the Mental Health Outreach Team, the Primary Care Mental Health Team should have assessed AC at this point. He told us that "primary care services had largely taken responsibility for his [AC's] management in the community, with intermittent support from specialist mental health services, so it is difficult to know why the PCMHT declined to assess him".¹³⁰ In his view, "its lack of engagement in this case compounded service difficulties."¹³¹

It is the case that the Substance Misuse Team had more contact with AC than any other of the medical teams. The SLaM report found that AC received "good substance misuse treatment according to national guidelines". The Lambeth PCT report found that "there is no evidence to support that AC's mental health issues were being addressed by the substance misuse team". They did not see the prescription of anti-psychotic medication as their responsibility. One of the doctors in the Substance Misuse Team, noted in the Medical Record in capital letters on 19 May "NEEDS OLANZAPINE." ... "NEEDS TO BE CONFIRMED WITH GP BY HEALTHCARE".¹³² However, this doctor did not for whatever reason prescribe the medication himself. Dr J, from the Mental Health Outreach Team, told us that the Substance Misuse Team "would have been able to prescribe olanzapine if it was required"¹³³.

¹²⁸ Email from Ms BD, PPO Supervisor/Assistant Psychologist, to the Primary Care Mental Health Team, 19 April 2010. Annex F. Also see page 30, first paragraph, second sentence, and footnote 24, page 30.

¹²⁹ Email from a Primary Care Mental Health Team member to Ms BD, 20 April 2010. Annex F

¹³⁰ Email from Dr J to Rob Allen, 17 February 2015. Annex Q

¹³¹ Ibid

¹³² Medical Record Printout, 19 May 2010, entry by Nurse F for a substance misuse doctor. Annex F

¹³³ Email from Dr J to Rob Allen, 17 February 2015. Annex Q

Two days later a member of the Substance Misuse Team, who we were told was a dual diagnosis worker, became concerned about AC's bizarre behaviour and referred AC to Mental Health Outreach for a comprehensive mental health assessment.¹³⁴

The Care UK report found that "at the time of the incident there was a lack of clarity regarding who should prescribe anti-psychotic medication. The GP's thought that these prescriptions should be made either by or under the supervision of the Psychiatrists."¹³⁵ The SLaM report found that there was "no agreed understanding between CARE UK GP's Substance Misuse and Outreach Mental Health as to who should prescribe the medication olanzapine, which had been prescribed by AC's GP in the community".¹³⁶

Who should have been responsible for prescribing olanzapine?

The Head of Health Care, Mr H, told us that there was in fact a protocol in place and that olanzapine should have been prescribed by a psychiatrist in the Mental Health Outreach Team. He was critical of the SLaM investigation report which found that "There was no real understanding between Care UK and SLaM, as to who should prescribe olanzapine. That's wrong."¹³⁷ Nurse K, who worked as a Primary Care Mental Health Nurse, also thought that "if it is an anti-psychotic medication, it should be the psychs".¹³⁸ Although GPs would prescribe it on the first night as happened in AC's case, "Outreach should have made sure that they were like sort of taking on that responsibility for him".¹³⁹ Nurse D, who worked in different parts of the health care system and who saw AC on 22 March, told us that "Normally, the antipsychotics are prescribed by the psychiatrist."¹⁴⁰ The problem in AC's case was that he never saw a psychiatrist in the mental health team while in Brixton.

¹³⁴ Medical Record Printout 21 May. Annex F

¹³⁵ Care UK report, page 10. Annex D

¹³⁶ The SLaM report, page 3. Annex D

¹³⁷ Interview with Mr H, page 19. Annex C

¹³⁸ Interview with Nurse K, page 7. Annex C

¹³⁹ Interview with Nurse K, page 17. Annex C

¹⁴⁰ Interview with Nurse D, page 9. Annex C

The Mental Health Outreach Team took a different view of responsibilities. Regarding the protocol described by Mr H, Dr J, a Consultant in Forensic Psychiatry in the Mental Health Outreach Team, told us on behalf of the healthcare providers at Brixton, “We do not accept that there is any such agreed protocol”.¹⁴¹ He told us that “AC had not seen a psychiatrist therefore the GP needs to be responsible for continued prescribing.”¹⁴² He continued, “GP’s send everyone with olanzapine to mental health. There is resistance by GP’s to continued prescribing. The mental health team could not prescribe without having seen AC”.¹⁴³ Dr J told us that the principle of equivalence applies, in that prisoners should receive the same range and quality of services as they would were they in the community. He told us that GPs in the community often prescribe anti-psychotic medication (as indeed they had in AC’s case) and in many cases, including prison cases, these prescriptions have also been initiated by GPs. “There were prisoners at HMP Brixton on antipsychotic medication who were not known to psychiatrists, and being managed by the GPs”.¹⁴⁴

During our investigation we interviewed SO Y, an experienced health practitioner who was among those who assisted at the incident of AC’s life-threatening self-harm on 4 June. Although SO Y was not involved in AC’s care prior to the incident, we took the opportunity to ask him where responsibility lay for prescribing anti-psychotic medication. He replied, “There were issues around that, that we had problems with the psychiatrist would be normally unwilling to write a prescription for any antipsychotic or other similar medications if he hadn’t seen the person. Which we could understand to some degree. But the GP was also saying, ‘Well, I’m not trained specifically in psychiatric medication, so I shouldn’t be.’ And there was that issue that I think they tried to resolve by saying, ‘The GP should give the minimum that they can for one week’. And then they would have to have an appointment with a psychiatrist within that week, and he would then agree to take over the care. But, again, with the Outreach, trying to get them sometimes to see the

¹⁴¹ Email from Dr J to Rob Allen, 17 February 2015. Annex Q

¹⁴² Note of telephone interview with Dr J, para 4. Annex C

¹⁴³ Ibid

¹⁴⁴ Email from Dr J to Rob Allen, 17 February 2015. Annex Q

patient and ... We did have ... It's, yeah, it's true to say that we did have problems getting antipsychotic medication because both had arguments: the GP saying, 'Well, I'm really not versed in doses of this or anything', and the psychiatrist saying, 'I've never seen the man and you're asking me to write a prescription for him?' Both were protecting themselves understandably, but, to some degree, I guess at the cost of the patient and the system really, that we were getting people who were quite unwell."¹⁴⁵

Nurse F put it more concisely when she told us that "I think everyone who was involved maybe thought it's someone else's responsibility."¹⁴⁶

Dr J, the Consultant Psychiatrist in the Mental Health Outreach Team, told us that in fact GPs are trained in prescribing psychiatric medication. He referred to guidance from the General Medical Council that doctors should not prescribe for patients they had not seen and, while the specific guidance "Good Practice in Prescribing and Managing Medicines and Devices" dates from 2013, he is of the view that at the time in question, namely early March to early June 2010, "psychiatrists were aware that they should not prescribe for patients they had not clinically reviewed, per guidance"¹⁴⁷ It is, in his view, "the responsibility of the doctor seeing the patient to prescribe for them. They have a duty of care to the patient in front of them".¹⁴⁸

Dr J told us that "The tripartite system worked well on the whole but GP's never came to weekly meetings despite an open invitation."¹⁴⁹ While attendance at such meetings might have solved the problems of cases such as AC's falling through the cracks between services, proper adherence to a clear protocol combined with frequent communication between practitioners involved in a case on a day to day basis would seem to be needed as well.

¹⁴⁵ Interview with SO Y, pages 9 and 10. Annex C

¹⁴⁶ Interview with Nurse F, page 23. Annex C

¹⁴⁷ Email from Dr J to Rob Allen, 17 February 2015. Annex Q

¹⁴⁸ Email from Dr J to Rob Allen, 17 February 2015. Annex Q

¹⁴⁹ Interview with Dr J, para 7. Annex C

The Clinical Review for this investigation states that “in preparing the chronology it is difficult to understand how and why not one of the prescribers who saw AC felt able to continue this prescription, despite the fact that his community GP record which clearly stated that he had this drug in the community was available from the 18th March.”¹⁵⁰

The SLaM and Care UK reports recommended clarification of roles and responsibilities between professionals in different teams and who is responsible for prescribing for any prisoner who has previously been prescribed medication in the community. This Article 2 Investigation has found that, as far as the prescribing of anti-psychotic medication is concerned, there is still confusion and lack of clarity. The Clinical review recommends that that the partners are clear about which service or services have responsibility for prescribing anti-psychotic medication and the systems to ensure it is prescribed in a timely fashion.

Finding Eight: **After the first ten days, the tripartite health care system in place failed to provide AC with the prescribed medication that he needed. A catastrophic lack of clarity about respective responsibilities led to a very poor level of medical care. This was compounded by poor communication between the various medical personnel who had contact with AC.**

Recommendation G: **The partners involved in providing health care to prisoners with mental health problems must be absolutely clear about which service or services have responsibility for prescribing anti-psychotic medication and develop systems to ensure it is prescribed in a timely fashion.**

¹⁵⁰ Clinical Review by Professor Jonathan Warren, page 12, para 4.11. Annex A

ii) Missed Appointments

Failure to attend medical appointments was a serious problem at Brixton during the period under review. HM Chief Inspector of Prisons (HMCIP) found in 2008 that around a quarter of dental and GP appointments were not kept and recommended work be undertaken to discover why.¹⁵¹ In its follow-up inspection carried out in December 2010, HMCIP found that there had been some efforts to collect data about prisoners who did not attend appointments. The number remained high and staff concentrated on chasing up prisoners at the time to ascertain reasons for non-attendance. They recommended further analysis of the 'did not attend' rates to focus appropriate action on improving attendance at relevant clinics.¹⁵²

The system of obtaining and attending appointments appears to have been that a slip was given to a prisoner the evening before the appointment and then they would be expected to make their own way if they were on freeflow. Officer W told us that landing officers had some responsibility. He described two scenarios. The first is where all prisoners are being unlocked for association. In that case, "So we're just unlocking them, they're going for their appointments – they know. Sometimes we need to chase them because they didn't come down and left the wing. But everyone is out and everywhere. Usually it's the desk officer chasing the landing officer, 'Can you get so-and-so because he's got a medical appointment but he probably doesn't know?'"¹⁵³

Officer W described another scenario as follows, "when we are locked up for that morning or that particular afternoon: we are unlocking and they do walk out. But we also have situations when you're by yourself on a landing, you're unlocking lots of prisoners, they're going out – and they tend to wander off

¹⁵¹ Report on an announced inspection of HMP Brixton 28 April – 2 May 2008 by HM Chief Inspector of Prisons, page 46, para 4.24. Annex M

¹⁵² Report on an unannounced full follow-up inspection of HMP Brixton 1–10 December 2010 by HM Chief Inspector of Prisons, page 58, para 5.24. Annex M

¹⁵³ Interview with Officer W, page 7. Annex C

and disappear for a while, and then they come back after half an hour, an hour. You think he's been to his visits, and probably he didn't – he go somewhere else.”¹⁵⁴

Mr H, the Head of Health Care, told us that a system for penalising failure to attend was considered. Appointments missed for no good reason could be taken into account as a part of the Incentives and Earned Privileges (IEP) Scheme¹⁵⁵, but this does not seem to have been pursued.

AC failed to attend a total of 14 health care appointments. On one of these occasions he was at court, on another he was in Visits. Four of the appointments that he did not attend were GP appointments, although it is not clear whether they had been made by AC or by the GPs as part of the follow-up planned to meet his mental health care needs. Four of the missed appointments were with the Blood borne Virus clinic and four with Substance Misuse. One appears to have been with a nurse (16 March) and the other was the appointment with the psychiatrist on 2 June.

The responses to AC's failure to attend appointments varied. The Substance Misuse Team followed up two missed appointments by visiting AC in his cell on 4 April. The GPs did not follow up in this way. Had AC been seen by a GP between 13 March and 21 May, the problem over the prescribing of olanzapine might have come to the fore sooner.

The missed appointment with the psychiatrist on 2 June was noted with a comment that the “Outreach CPN to monitor him as per his zoning and let me know if any concern.”¹⁵⁶ There is no reference to a further appointment being made.

¹⁵⁴ Ibid, page 8. Annex C

¹⁵⁵ Interview with Mr H, Head of Health Care, page 43. Annex C

¹⁵⁶ Medical Record Printout, 2 June 2010, entry by Dr M. Annex F

The Care UK report found a lack of apparent compliance with the “DNA protocol” – that is the procedure for responding to missed appointments. The report finds that “follow up of DNAs is crucial to identify patients who are in danger of slipping through the net”.¹⁵⁷

Specific failings were found in relation to the protocol’s requirements, firstly to ensure that the appointment is clearly communicated to the patient, and secondly, in the event of a failure to attend, that best efforts must be made to engage with the prisoner to discuss why they did not attend that appointment and to establish if it is suitable to rebook an appointment (with a written entry made on the Medical Record).

There is no evidence in the records that any of the appointments was clearly communicated to the patient. Out of 14 reports of appointments where the prisoner failed to attend, there are six episodes of reported follow-up on the electronic record and one episode where follow-up by another team member was intended.

Where follow-up took place it was most often in the case of the Blood borne Virus clinic and the Substance Misuse Team. The latter visited AC in his cell on 4 April after he missed two appointments. The missed GP appointments were followed up on only one occasion, namely on 18 April when it is recorded that [AC] “didn’t think he needs to attend for repeat meds”¹⁵⁸ but nothing further is noted.

Finding Nine: AC’s failure to attend his GP appointments should have been much more vigorously followed up by the Primary Care Team.

¹⁵⁷ The Care UK report, page 13. Annex D

¹⁵⁸ Medical Record Printout, 18 April 2010. Annex F

Recommendation H: A much more robust system should be in place to account for missed medical appointments. This system should explore reasons for non-attendance, emerging patterns of non-attendance and identify vulnerable prisoners. As happened with the Substance Misuse Team, two consecutive failures to attend GP appointments should trigger a visit to the patient in their cell.

As for the missed appointment with Dr M from the Mental Health Outreach Team on 2 June, it appears that AC may have been unable to attend because he was not permitted to leave his cell. AC had been sentenced to 14 days loss of association at an adjudication hearing on 29 May. On 1 June AC smashed the TV in his cell and on 2 June he was given a Red Entry at 12.12 pm after he had become rude and abusive towards another prisoner and refused to return to his own landing. His failure to attend the appointment was noted at 15.33. The SLaM report notes that Dr M, with whom AC had the appointment, told the investigation that AC “was on controlled unlock due to a fighting incident and therefore could not be let out of his cell for the appointment”.¹⁵⁹

Finding Ten: AC should have been escorted by prison staff to his appointment with the psychiatrist on 2 June.

It is difficult to ascertain what, if any, follow-up was planned for AC’s appointment with Dr M on 2 June. The appointment had been made following a referral made by a member of the Substance Misuse Team on 21 May and Dr M refers to it as a review. In fact, the referral was for a comprehensive mental health assessment and the consultation would have been AC’s first with a psychiatrist from the Mental Health Outreach Team. Given the widespread concern that had been expressed about AC’s deteriorating mental

¹⁵⁹ SLaM report, page 9. Annex D

health, from within the prison and by AC's sister LC, his solicitors and his community-based GP, a more urgent follow-up was needed.

Recommendation J: When a prisoner is identified as requiring assessment by a psychiatrist, he should be escorted to that appointment where necessary. If, for whatever reason, such an appointment is missed, medical staff should ascertain the reasons for the missed appointment on the same day.

Chapter Eleven

The Care of AC by Prison Staff

i) Wing Moves

AC spent his relatively short period in Brixton in four different wings. He spent the first week on C Wing where most prisoners spent their first few days, before moving to G Wing which housed prisoners such as AC with substance misuse problems. He stayed on G Wing for six weeks, being moved to A Wing after seriously assaulting another prisoner. He remained on A Wing for just over three weeks when his mental health deteriorated. After an assault on 22 May and the discovery of broom handles in his cell, AC was moved again, on 24 May, to B Wing. He spent the following 11 days on B Wing, where his behaviour became even more problematic. On 4 June, the day of the incident of life-threatening self-harm, AC was trying to get a further move off B Wing.

As far as the movement between the wings is concerned, Ms BB, the then Head of Safer Custody and Head of Psychology, who undertook the Brixton internal investigation into the case told us that there was nothing particularly of concern about the moves.¹⁶⁰ AC requested some of the moves, in part it was thought because he had run up debts with other prisoners. On 21 May he is recorded as having alluded to drug debts “but says he has not been threatened.”¹⁶¹ On 27 May, the B Wing Observation Book notes that AC has “acrewed [accrued] debts on other wings (which is why he is on B Wing). He is probably using us to separate him”¹⁶²

¹⁶⁰ Interview with Ms BB, page 62. Annex C

¹⁶¹ Medical Record Printout, 21 May 2010. Annex F

¹⁶² B Wing Observation Book, 27 May 2010. Annex G

AC told a Substance Misuse doctor in mid-April that he was smoking heroin “about once a week”.¹⁶³ This would no doubt have incurred costs. On 29 May he was also sentenced to 14 days loss of canteen which may have forced him to obtain tobacco from elsewhere. Officer O explained how prisoners can build up a debt; “can’t pay the debt back so he needs to get off the wing. ‘Cause a lot of them will build up debt, and they’ll jump from wing to wing, till they’ve got nowhere else to go – because of debt build-up.”¹⁶⁴ Officer O confirmed that if a prisoner had loss of canteen, for example following an adjudication, they would have to buy tobacco from someone. “Or borrow it. And then if you borrow a quarter, you give ‘em a half back when you get your canteen back. But then that’s if you’ve got sufficient funds to be able to borrow that. ‘Cause if you can only afford a half then, you’ve gotta give them that half back, but then you gotta borrow a quarter again, then you gotta give ‘em another half. So it’s just ... it escalates. And some of them – actually, it just gets out of control. They could borrow off two or three different people. Even a pack of Rizlas – borrow a pack of Rizlas, pay two back.”¹⁶⁵ “And the punishment for not paying a debt is getting a slap – or worse.”¹⁶⁶

Officer O agreed that some of AC’s behaviour might have been designed to get him off the wing or even get into the CSU. While on A Wing on 20 May AC is noted as becoming “abusive” and saying “he would knock out staff and demanding to go to the CSU”.¹⁶⁷

Officer W thought that AC was in debt to other prisoners, although SO P did not agree. She described an unusual situation in which AC tried to give away a lot of tobacco and chocolate to other prisoners; staff had to intervene.

There were limited efforts made to get to the bottom of the debt issue. As Officer O said, “we’ve got management plans and support plans, but it’s gotta happen in front of us. If it’s happening in the cell, you got – I think on B Wing

¹⁶³ Medical Record Printout, 19 April 2010. Annex F

¹⁶⁴ Interview with Officer O, page 2. Annex C

¹⁶⁵ Ibid, page 3. Annex C

¹⁶⁶ Ibid, page 4 Annex C

¹⁶⁷ A Wing Observation Book, 20 May 2010. Annex G

you got 44 cells on a landing. And you got people in and out of cells all the time during Association. It can happen as quick as anything in a cell. And that ... I think at that time we didn't have the cameras installed either, so ... I mean we'd no CCTV to see if he was in and out of cells or see if he's hit someone or someone's tried to corner him or persuade him to come in a cell for a chat. 'Cause it makes it ... If we know that there's two or three people gone into a cell, and someone that ... You get two people that you know regularly wouldn't talk to each other, and then all of a sudden they're best mates and he's trying to get him into a cell for a chat, you know something's going to happen."¹⁶⁸

Trying to establish whether AC was in debt would not have been easy. It is clear from the notes and interviews with staff that AC was not a communicative prisoner. Officer W said that AC "was not a person that would talk with staff. He would not interact very easily".¹⁶⁹ SO P told us "you couldn't really stand in front of him and kind of have a normal conversation 'cause he was very you know, fidgety, and he moved around quite a bit".¹⁷⁰ Ms BB, the then Head of Safer Custody and Head of Psychology, who wrote the Brixton internal investigation report, told us that "the staff were adamant that they had asked him a number of times about this being an issue and about giving them some information about who to, where, you know, what was the circumstances – those sort of things, so they could act on it, and he would not do so."¹⁷¹ Despite this, greater efforts could have been made to get to the root of AC's difficulties rather than simply shunt him from wing to wing.

Finding Eleven: More effort could have been made by prison staff to identify what lay behind AC's unusual behaviour on the wing, including the nature and extent of his debts.

¹⁶⁸ Interview with Officer O, pages 4 and 5. Annex C

¹⁶⁹ Interview with Officer W, page 1. Annex C

¹⁷⁰ Interview with SO P, page 4. Annex C

¹⁷¹ Interview with Ms BB, page 64. Annex C

ii) Links with Health Care

The uniformed staff were aware that AC had problems. SO P said “something wasn’t totally right. And we all knew.”¹⁷² Officer W told us that “he was a quite angry person. He was always angry.”¹⁷³ When AC’s mental health started to deteriorate in mid-May, the uniformed staff did make efforts to obtain a mental health care assessment and treatment. Staff in the Visits hall were concerned about him and it is recorded on 21 May that an officer asked the Primary Care Mental Health team to see AC – which they did.¹⁷⁴ This referral is referenced in a letter which AC’s sister, LC, sent to the prison outlining her concerns about her brother’s declining mental health.¹⁷⁵ The next day, 22 May, a wing Senior Officer, SO L, referred AC to the same team.¹⁷⁶ In each case AC was seen promptly, and in the case of the second meeting a discussion with Mental Health Outreach was planned.¹⁷⁷ Officer T also told us that he alerted management and healthcare about AC because he thought AC should be assessed and even placed in the health care unit.

Officers on B Wing after 24 May were also concerned. Officer W, who worked on B Wing, told us that “we had a bit of a concern; we discussed it in morning briefing one morning, about his mental health situation”.¹⁷⁸ Officer W “put an application form for someone from the Outreach to come and see him and interview him, because we had a little bit of concerns about his behaviour.”¹⁷⁹ He did not know if they did anything to follow up. There is no reference to this in the Medical Record.

¹⁷² Interview with SO P, page 7. Annex C

¹⁷³ Interview with Officer W, page 6. Annex C

¹⁷⁴ Medical Record Printout, 21 May 2010. Annex F

¹⁷⁵ Letter from LC. Annex J

¹⁷⁶ Medical Record Printout, 22 May 2010, entry by Nurse K, Primary Care Mental Health Team. Annex F

¹⁷⁷ Ibid

¹⁷⁸ Interview with Officer W, page 2. Annex C

¹⁷⁹ Ibid

The health care staff who dealt with AC were not, however, fully aware of the problems he was causing on the wings. The SLaM investigation team formed the opinion that “communication is poor between prison staff and health care services, for example health care services were unaware of AC’ fighting incidents and his mood/behaviour changes as noted in the prison’s observation book.”¹⁸⁰

We have not found any evidence that staff ignored or played down AC’s symptoms because they thought he was feigning them in order to obtain a medical hold. It is the case that AC, his solicitors and his sister, LC, raised the question of AC remaining at Brixton in the event of conviction. A worker at Lambeth End2End Case Management also noted in an email on 2 June to AC’s PPO Supervisor, Ms BD, that AC was “trying to get himself on medical hold on mental health grounds”.¹⁸¹

Mr H, the Head of Health Care, told us that such medical holds were rarely granted for mental health issues and when they were, it was for patients in the Health Care Centre awaiting transfer to a specific local hospital or for a period of assessment in D Wing.¹⁸² Officer T told us that he thought AC might have been appropriately accommodated in the Health Care Centre¹⁸³. This was not the view of the Mental Health Outreach Team which did not consider that AC suffered enduring mental health symptoms.¹⁸⁴ Following a conversation with AC’s community-based GP on 20 May, Dr G found “no contraindications for transfer here expressed”.¹⁸⁵

Although it can be argued that the health care response to AC underestimated the severity of his symptoms, these were in any event likely to have been some distance from the threshold for a transfer to a hospital in the community.

¹⁸⁰ SLaM Report, page 14. Annex D

¹⁸¹ Annex J

¹⁸² Interview with Mr H, Head of Health Care, pages 31, 34 and 35. Annex C

¹⁸³ Telephone interview with Officer T, page 1, para 3.

¹⁸⁴ Medical Record Printout, entries on 10 May and 24 May 2010. Annex C

¹⁸⁵ Medical Record Printout, 20 May 2010, entry by Dr G. Annex C

We were told that there was a system in place for managing so-called complex cases such as AC. But AC does not seem to have been included in it. The then Head of Psychology who was also Head of Safer Custody, Ms BB, told us that “the idea was that we would have about ten to twelve cases on the books who would involve close monitoring by the managers of the different departments”.¹⁸⁶ Nurse K said that “we used to take them as complex cases to the Complex Case Meeting, where the whole prison would be involved. And then again, it would be sort of like confidential issues and things like that.”¹⁸⁷

Ms BB said that “Because the system hadn’t caught [AC], and we were aware that he was a case that should have been caught by that process, that we revised how we identified these cases and rewrote the terms of reference for the Complex Cases”.¹⁸⁸ The Head of Health Care, Mr H, told us that complex case meetings were introduced after the AC case, in part as a result of it.¹⁸⁹

Whether or not the Complex Cases system was in place at the time, AC did not benefit from the approach which would have pooled information about his attitudes, behaviour and health care problems and enabled a coordinated approach to his management. Such an approach is essential for people, who, as Nurse K put it, “will bounce around the different services”.¹⁹⁰

Finding Twelve: Prison staff made appropriate referrals to mental health in the second half of May but did not communicate to health care staff the problems AC was causing on the wing.

¹⁸⁶ Interview with Ms BB, page 53. Annex C

¹⁸⁷ Interview with Nurse K, page 13. Annex C

¹⁸⁸ Interview with Ms BB, page 53. Annex C

¹⁸⁹ Interview with Mr H, pages 3 and 13. Annex C

¹⁹⁰ Interview with Nurse K, page 14. Annex C

Recommendation K: A multi-disciplinary system for managing Complex Cases should be in place to deal with prisoners such as AC who suffer from a combination of health and behavioural problems.

Chapter Twelve

Were the unprovoked assaults carried out by AC properly investigated and appropriately dealt with?

AC was subject to adjudications following three incidents. On 14 May he was given a punishment of 21 additional days of imprisonment. Since AC was on remand awaiting trial, these days would have been added to any prison sentence imposed in the event of his conviction. On 29 May, AC was punished by a loss of privileges for 14 days. He forfeited association (leaving his cell to mix with other prisoners during recreation periods), canteen (the ability to purchase items) and the use of the television in his cell. On 3 June, the same loss of privileges was imposed for a further 14 day period. In addition, on 4 June AC was moved from the Standard regime to the Basic regime in the IEP Scheme.

The most serious of these incidents was an assault that took place on 29 April and which was dealt with by an Independent Adjudicator on 14 May. The Independent Adjudicator noted that AC said by way of mitigation, "It's about abuse and threats. Verbally threatened for months. Afraid." ... "People calling me a grass, knowing my address, my sister's address. I'm an emotional wreck: I'm being broken. Can't get my proper medication. Shd be olanzapine. Blurred vision now. Fuzzy hearing. I've now been moved : on A Wing now. But it's worse."¹⁹¹

There is no record of whether the Independent Adjudicator passed this information on to the wing or health care staff. This was a missed opportunity to address AC's lack of olanzapine.

Finding Thirteen: **The Independent Adjudicator should have alerted prison and health care staff to AC's self-reported distress.**

¹⁹¹ F256 Record of Adjudication Hearing, Charge number 270492. Page 3, section 14. Annex H

Recommendation L: When prisoners raise medical issues in adjudications, the information should be passed on to the appropriate health care services.

There were further missed opportunities to address AC's broader mental health and wellbeing at the two subsequent adjudications. Both took place after AC's mental health had deteriorated. On 27 May AC was involved in an attempted assault of another prisoner who came to his cell door. An entry in the Wing Observation Book notes that "I believe [that [AC] has mental health issues, he refuses to interact with anybody and is always angry and agitated. I overheard a few prisoners saying that he should be relocated to another wing as he has upset many other prisoners."¹⁹² He had a further outburst on 1 June, receiving a Red Entry on the P-NOMIS recording system for being rude and abusive to another prisoner and not returning to his own landing. He was given an IEP warning for this on 2 June. AC assaulted another prisoner on 3 June and was moved from the Standard to the Basic Regime. This would have made no difference to AC because of the privileges he had forfeited on 29 May.

There was no substantive input into the adjudications from a health care perspective. From a disciplinary point of view, the sanctions imposed were not in themselves unduly harsh; however, the impact of loss of canteen, association and television on a prisoner with mental health problems is likely to be very much greater than on a prisoner without such problems. Loss of association results in more isolation from other people and fewer opportunities for communication, while a loss of television deprives a person of a means of diversion and relaxation. It is possible that AC smashed his TV on 1 June in frustration at it being switched off following the adjudication three days earlier on 29 May. Paradoxically, had AC served his punishment awards in the Care and Separation Unit (CSU), the likelihood is that his deteriorating mental health would have been noticed and appropriate action taken. CSU staff are generally more experienced in dealing with prisoners who are isolated from the main groups.

¹⁹² B Wing Observation Book, 27 May 2010. Annex G

Recommendation M: Possible adverse consequences on a prisoner’s mental health should be taken into account in imposing punishments and forfeitures at adjudications.

The prison discipline system can only provide a partial solution to the problem of a prisoner committing a series of unprovoked assaults. Brixton had developed a system of dealing with bullying and violence by opening up a Perpetrator Plan. This is a tool for recording and managing the behaviour of persistently difficult prisoners, particularly those involved in bullying.

The Independent Monitoring Board (IMB) Annual Report for 2010 reported that in 2010 “the use of perpetrator management and victim support plans is minimal and the standards of completion vary. The SCG (Safer Custody Group) has done some work this year to raise the profile of these documents (by printing them on blue paper) but their use is still very low.¹⁹³ Monthly Minutes of the Safer Custody Meetings held at Brixton show that in March 2010 18 Perpetrator Plans were opened and 16 closed¹⁹⁴, in April eight were opened and seven closed¹⁹⁵, in May ten were opened and five closed¹⁹⁶ and in June thirteen were opened and ten closed.¹⁹⁷

Officer W described the Perpetrator Plan as “a daily observation, a daily entry, where we note – a small note, a couple of lines – just to create a picture of what they’re doing during the day, in the morning and in the afternoons. Is he going always in the same cell? Is he always arguing with the same people? Just the general behaviour about him.”¹⁹⁸ The Wing Observation Book notes that on 3 June “Perp Plan updated”.¹⁹⁹ Other than this entry, we have been unable to locate any documentary evidence that AC was in fact subject to such a plan. The Brixton internal investigation was also unable to locate any such evidence.

¹⁹³ HMP Brixton Independent Monitoring Board Annual Report to the Secretary of State, 1st September 2010 to 31st August 2011, page 14. Annex M

¹⁹⁴ Safer Custody Meeting on 7 April 2010. Minutes, page 11. Annex N

¹⁹⁵ Safer Custody Meeting on 5 May 2010. Minutes, page 8. Annex N

¹⁹⁶ Safer Custody Meeting on 2 June 2010. Minutes, page 9. Annex N

¹⁹⁷ Safer Custody Meeting on 7 July 2010. Minutes, page 11. Annex N

¹⁹⁸ Interview with Officer W, page 4. Annex C

¹⁹⁹ B Wing Observation Book, 3 June 2010. Annex G

AC certainly should have been managed in this way given the series of unprovoked assaults which he committed. Officer O told us that “he could have been bullying people for tobacco. If he’s gone round certain people and they’ve heard that he’s a borrower but he won’t pay back, save them giving him a slap, they won’t lend it to him. So he’ll go round picking on the weaker people, and he’ll steal their tobacco.”²⁰⁰ Whether this is the case could have been established by placing AC on the plan.

Finding Fourteen: It is not absolutely clear whether AC was subject to a Perpetrator Plan and, if he was, what this entailed.

A final issue about AC’s care is whether at any point during his stay at Brixton, he should have been made subject to suicide and self-harm monitoring (an ACCT Plan)²⁰¹.

The incident of self-harm on 4 June came as a surprise to almost all of the staff whom we interviewed. Indeed, some questioned whether AC actually intended to harm himself, suggesting he might have slipped off the pipe at the back of the cell on which he was standing. The surprise is consistent with the fact that at no time during the period under review was AC made subject to an ACCT, other than after the incident of life-threatening self-harm on 4 June. The Medical Record shows that during a previous period in Brixton in 2007, AC had been subject to an ACCT.²⁰²

The Medical Record shows that AC denied thoughts of suicide in consultations on four occasions: 8 March, 19 April, 22 May and 24 May. Wing staff did not consider him to be at risk. Officer W told us, “No, he never self-harmed himself, he never gave any signs, he never said any[thing] ... to any member of staff that he felt suicidal.”²⁰³

²⁰⁰ Interview with Officer O, page 4. Annex C

²⁰¹ Assessment, Care in Custody and Teamwork Plan [The care-planning system used to help to identify and care for prisoners at risk of suicide or self-harm]

²⁰² Medical Record Printout, 12 January 2007, entry by a doctor. Annex F

²⁰³ Interview with Officer W, page 4. Annex C

Ms BB, the then Head of Safer Custody and Head of Psychology, who wrote the Brixton internal investigation report, told us that “We had 65 ACCTs open when I left Brixton in 2011, which is something like nine per cent or eight per cent of the population. So they are very aware that if they thought there was a risk, I think they would have opened one.”²⁰⁴

Nurse C told us that he had “opened a lot of ACCTs in the past, in Brixton Prison, but at the time – last time I’ve seen AC face to face, I didn’t get the impression, or him pointing out, there was any specific thought, plan or intent of harming himself. So, there was no suggestion that an ACCT would have been needed at the time.”²⁰⁵ Indeed, the entry made by Nurse C on the Medical Record on 24 May states that AC “Currently denies any DSH [deliberate self-harm]/suicide ideations, plans or thoughts”.²⁰⁶

However, Nurse C told the Care UK investigation that after he saw AC on 24 May the patient was “appropriately managed on ACCT on the wing as a precaution for individual who appeared at risk”.²⁰⁷ The Care UK report notes that “this is not factually true”.

We have been unable to obtain the copies made of the statements made to the Care UK investigators and we are therefore unable to explore this discrepancy. It is possible that Nurse C was under the mistaken impression that AC was on an ACCT Plan.

Finding Fifteen: **There is an important discrepancy between what was told by Nurse C to the Care UK investigation and to us about whether he thought AC was subject to an ACCT.**

²⁰⁴ Interview with Ms BB, page 68. Annex C

²⁰⁵ Interview with Nurse C, page 41. Annex C

²⁰⁶ Medical Record Printout, 24 May 2010, entry by Nurse C. Annex F

²⁰⁷ Care UK report, Appendix 1, page 31/42. Annex D

Chapter Thirteen

Was appropriate contact kept between the prison and AC's relatives?

LC, one of AC's two sisters, was to all intents and purposes his carer in the period prior to his imprisonment. AC had lived with her for a while before living in a squat and then, during 2009, obtaining his own flat. LC told us that AC had been taking olanzapine for about five years, at a dosage of between 10 and 20 mg. LC had often collected the olanzapine from the pharmacy and made sure her brother took it. In fact, the records suggest that AC took olanzapine sporadically outside prison.²⁰⁸

When AC was in Brixton, LC visited him regularly and kept in telephone contact. AC wrote a number of letters to her.

LC became concerned about her brother's deteriorating mental health. During visits he appeared distant, paced up and down and was not always making sense. On four or five occasions AC did not turn up for visits and had to be collected, which was something LC considered to be another sign of his worsening mental health.

LC told us that she approached prison officers in Visits and told them that her brother was not taking his pills. One of these officers asked her if he was storing the pills and said that if he was not taking the medication, there was nothing they could do about it. Another officer, who had previously worked in health care, phoned through and arranged for AC to be seen by someone from health care. This is recorded in the Medical Record on 21 May.²⁰⁹

LC wrote a letter to the prison dated 18 May outlining her concerns about her brother's condition and his need not only to be prescribed olanzapine but to be supervised in taking it. There is no reference in the Medical Record to the letter being received, although Mr H, Head of Health Care, remembers the letter. There is also no record of a response.

²⁰⁸ Care UK report, page 40, in Appendix 5. Annex D

²⁰⁹ Medical Record Printout, 21 May 2010. Annex F

LC also asked AC's solicitors to write a letter to the Governor. The solicitors' letter, dated 20 May, did elicit a response and appears to have galvanised the prison into action. LC was concerned that the letter of reply from Dr J, Consultant in Forensic Psychiatry in the Mental Health Outreach Team, asked for AC's medical records which the prison had in fact received more than two months before.

At this stage, the prison began to recognise the key role which LC played in her brother's care. It is noted that Nurse C tried to call LC on her mobile phone, but he told us that he could not get through. LC told us that there was no voicemail message left. No further effort was made to contact her.

It is the case that on the P-NOMIS electronic prison recording system, AC's next of kin is recorded not as LC but as his other sister, DC. On the Personal Summary Sheet which forms part of AC's Core Record, no next of kin is recorded.²¹⁰ LC feels that the prison failed to act on the information that she tried to provide and that it made inadequate efforts to engage with her. We agree.

Finding Sixteen: HMP Brixton failed to acknowledge the key role of AC's sister in his care or to engage constructively with her during his period in custody.

²¹⁰ F2050 Core Record. Annex G

Chapter Fourteen

How well did staff respond to the incident on 4 June 2010?

What is the likeliest explanation for the inability to remove the plate on the cell door in the normal way?

A number of issues arise in relation to the handling of the incident on 4 June.

i) Dealing with AC's request to move

The first relates to the handling of AC's request to move off B Wing on 4 June. On the day before, 3 June, a B Wing Observation Book entry notes that AC "cannot go to A or G Wing. Attempts to move him to C Wing are a slow process". Spoke with Governor AA who is looking into a SIR from previous week involving a similar incident. No answer as yet".²¹¹ By the next morning, Friday 4 June, the Duty Governor Handover Checklist includes an entry at 7.55 a.m. that AC to go to G Wing.²¹²

However, SO P, who was the Senior Officer on B Wing on Friday 4 June, told us that on that morning she said to, "I think Governor AB that he wants to go back to G Wing and she told me he can't go back."²¹³ SO P also told the Brixton internal investigation that Governor AB said AC was not to move and should be managed on the current wing. Brixton's internal investigation report considers that "this would appear to have been a likely and appropriate management plan as AC had been located on all of the 3 main residential wings in previous weeks and the movement had not impacted on his violent behaviour".²¹⁴

²¹¹ B Wing Observation Book, 3 June 2010. Annex G

²¹² Duty Governor Handover Checklist, 4 June 2010. Annex G

²¹³ Interview with SO P, page 2. Annex C

²¹⁴ Brixton internal investigation, page 5, para 26. Annex D

Finding Seventeen: It is not clear why the decision to move AC to G Wing seems to have been reversed during the morning of 4 June.

Once AC had barricaded himself into his cell and made a noose, he demanded to be moved. SO P told him that he could not. Officer T who was negotiating with AC told us that AC “kept saying ‘I told them I have to get out of the cell’. AC said that he had told an officer earlier that he had to get out but that this had been refused.”²¹⁵ Officer T thought that AC “may have been fearful for his safety inside his cell or hearing voices and that this should have been considered by the wing staff.”²¹⁶

SO P told us that during the incident of life-threatening self-harm the decision about moving AC was again changed. Governor V said to her that there was after all a cell for him on G Wing. It is not clear whether this offer of a move was made after AC had put the noose around his neck.

ii) Notifying staff about the incident and the staff’s response

The second issue concerns the way in which staff were notified about the incident as it unfolded and asked to assist. It is unclear whether a radio call was made immediately or whether staff were shouted for or telephoned. There seems no doubt that sufficient uniformed staff arrived on the scene quickly. They responded rapidly to the unfolding incident and, for the most part, acted effectively. The documents and interviews available to this investigation do not allow us to identify who was in charge or whether particular procedures in a contingency plan were being followed. But, in a fast-moving emergency, staff reacted well. The incident was particularly distressing for those staff who had to observe AC hanging while unable to assist him.

²¹⁵ Telephone interview with Officer T, page 1, para 4. Annex C

²¹⁶ Ibid

We note that the Brixton internal investigation recommended that, in the event of an incident of barricade or potential suicidal behaviour, contingency plans are managed by the Duty Governor.²¹⁷ We concur, with the proviso that this should not delay a response in an emergency.

Finding Eighteen: **Staff reacted well to the incident, although it is not clear whether contingency plans for barricades were followed to the letter.**

Recommendation N: **We endorse the recommendation made by the Brixton internal investigation that, in the event of an incident of barricade or potential suicidal behaviour, contingency plans are managed by the Duty Governor. We would, however, add the proviso that this should not delay a response in an emergency.**

Once it became clear that the heel plate could not be removed, a locksmith was notified. The locksmith, Mr X, told us that he was having lunch when he was told to attend B Wing as someone had barricaded themselves in their cell.²¹⁸ He was not told that the incident was a Code 1 or medical emergency. In his interview with us Mr X said that, while making his way over, he was asked to hurry up as it was a Code 1 or medical emergency. He had thought it was simply a barricade.

Finding Nineteen: **On 4 June, the call to the locksmith should have been clearer about the level of urgency of the situation he was being asked to respond to.**

²¹⁷ The Brixton internal investigation report, page 13. Annex D

²¹⁸ Interview with Mr X, page 2. Annex C

It also emerged during our interview with Mr X that a locksmith is not readily available at all times at the prison. In the evenings and at weekends, a locksmith could be called to attend but there would be a delay as they would not be on site at these times.

Recommendation O: HMP Brixton should review the availability of a locksmith in the evenings and at weekends.

As for the response by health care staff, it seems that while Hotel 6 (the emergency response nurse) was at the cell when the door was opened, other nurses arrived shortly afterwards with resuscitation equipment. This delay might have been avoided if a Code 1 medical emergency call had been made sooner. It was clear from the outset that a noose had been made and, while staff may have hoped that the incident could have been concluded without harm, it would have been better if more health staff, with resuscitation equipment, were already on the scene when the door was opened. The entry on the P-NOMIS record states that “a Code 1 was called before we were in the cell so that medical staff were on the scene.”²¹⁹ The log taken by Officer W has the staff entering the cell at 12.52 while the Communications Log notes the Code 1 at 12.55.

The Care UK report finds a number of ways in which the response failed to comply with the Medical Emergency Code Protocol although, in itself, this did not affect the outcome for the prisoner. The Code 1 should trigger an ambulance being called. The Communications Log shows a three-minute delay between the Code 1 at 12.55 and the ambulance being called at 12.58.²²⁰

Finding Twenty: A Code 1 should have been called over the radio at an earlier stage. The ambulance should have been called at the same time as the Code 1.

²¹⁹ P-NOMIS. Annex G

²²⁰ Communications Log. Annex G

iii) Opening the door

Clearly, the cell door would have been opened much more quickly had the third screw in the heel plate not been jammed. It is not clear what material was blocking access to the screw; toothpaste, glue, paper, paint, and melted plastic cutlery have all been suggested. Whatever the material was, it was rock-hard and could not be removed with the equipment that the wing staff had at their disposal.

The Independent Monitoring Board (IMB) Annual Report for 2010 mentions the incident of life-threatening self-harm involving AC, describing a delay in reaching him “because he had jammed the lock on his cell door²²¹. There is, however, no evidence that AC had himself placed the material in the lock. He had been on B Wing a short time and much of that time he had been locked in his cell. He is unlikely to have been responsible. Equally, it seems unlikely that anyone else would have deliberately targeted his cell.

At the time of the incident, the screws on the heel plates of cells were checked as part of a six-monthly maintenance operation. AC’s cell had been checked in January 2010. Following the incident, all of the cells were checked and a small number of other blockages were found and cleared. Thereafter, the heel plates were checked weekly, although the frequency reduced after Brixton changed from being a Category B prison to a Category C. Officer S told us that “any inundating points are checked on a regular basis. The paint is a different colour now.”²²² This refers to the fact that the heel plate is now painted a bright yellow to show that it should not be repainted over during any further wing decorating.

²²¹ HMP Brixton Independent Monitoring Board Annual Report to the Secretary of State, 1 July 2009 to 31 August 2010, page 11. Annex M

²²² Interview with Officer S, pages 21 and 22. Annex C

Additional tools have been placed on the wings. Mr X, the locksmith, told us, "I think now. I know they've got an hammer, they've got an Allen key, and they've got the thing what you get the ... dig out the stuff they put tissue paper on. Every wing's got one".²²³ Mr X added "I'd like to see that, if possible, that the officers should get like a ... one of the little electric drills to use to get them, the bolts, out, because I reckon to use them Allen keys takes too long".²²⁴

Recommendation P: Consideration should be given to placing 'Impact Screwdrivers' into each wing office to facilitate the removal of seized and damaged bolts on anti-barricade lock plates.

Recommendation Q: The daily cell fabric check should include the inspection of the securing bolts on the anti-barricade lock plates.

²²³ Interview with Mr X, page 10. Annex C

²²⁴ Ibid, page 16

Part Four. Observations about Investigation procedure

Chapter Fifteen: Earlier Investigations into the case

Four reports had been prepared about the case of AC, prior to this Article 2 Investigation. The Brixton internal investigation was commissioned on 4 June 2010 and completed on 30 July 2010. The South London and Maudsley NHS Foundation (SLaM) report was commissioned on 22 June 2010 and completed on 23 September 2010. The Care UK report was completed in January 2011. The Lambeth Primary Care Trust report is undated.

The four earlier investigations had varying terms of reference and methods of work. The findings and recommendations made by them have been mentioned at appropriate points in this Article 2 Investigation report. For the most part, the findings and recommendations made by this report are consistent with those already made by the earlier investigations, although there are some exceptions. The exceptions have been considered in previous chapters.

This Article 2 Investigation considers it important to make the following two observations, however.

First, the multiplicity of investigations undertaken into this case reflects the fragmentation of responsibilities within the prison. The Brixton internal investigation did not have access to the medical records “due to medical in confidence issues”.²²⁵ The Care UK and SLaM reports were limited to health care interventions. The objectives of the Lambeth PCT review were slightly broader in seeking to establish the circumstances and events surrounding AC, including the health care provided by the Prison Service and relevant outside factors. But all of Lambeth PCT’s recommendations relate to health care.

²²⁵ Brixton internal investigation report, page 1, para 1. Annex D

While it is positive that each of the key agencies involved in commissioning and providing care for AC were interested in establishing what, if anything, went wrong and to learn lessons, it might have been more effective for Lambeth PCT, Care UK and SLaM to have commissioned a single, comprehensive investigation so that agreed findings and recommendations could have been made and a joint implementation plan put in place.

Finding Twenty-One: Lambeth Primary Care Trust, Care UK and the South London and Maudsley NHS Foundation Trust (SLaM) should have commissioned a single investigation into the care of AC in Brixton.

Second, it is not clear what the status are held by the recommendations that have been made, whether or not they have all been accepted by the relevant parties and whether those that have been accepted have been implemented. It has been beyond the scope of this investigation to consider the question in detail. We are, however, concerned that perhaps the most central of the recommendations, namely Recommendation G, about the need for clarity in respect of responsibility for prescribing anti-psychotic medication, does not appear to have been resolved three years on.

Chapter Sixteen

The Appropriate Level of Public Scrutiny

The commission to conduct an Article 2 Investigation requires the independent investigator to provide a view as to what would be an appropriate element of public scrutiny given the circumstances of the case. Public scrutiny forms an important aspect of the investigative obligation under Article 2 of the European Convention on Human Rights. Accordingly, I have considered carefully whether the publication of the final version of this report will be sufficient to satisfy the requirement for public scrutiny or whether some further stage in the investigation is needed, such as a public hearing. I have reached the view that a further stage may be required. The main reason for forming this view relates to one of the key findings from the investigation. This is Finding Eight:

After the first ten days, the tripartite health care system in place failed to provide AC with the prescribed medication that he needed. A catastrophic lack of clarity about respective responsibilities led to a very poor level of medical care. This was compounded by poor communication between the various medical personnel who had contact with AC.

The finding relates to one of the most significant issues that emerged from the investigation, namely that there was a fundamental disagreement between the three parts of the health care service within HMP Brixton about who should be responsible for prescribing anti-psychotic medication in a case such as AC.

Was prescribing anti-psychotic medication a responsibility for the prison-based General Practitioner? In this regard, the Consultant Psychiatrist from the Mental Health Outreach Team told us that in the community the GP would prescribe it. Indeed, that had happened in the community in AC's case. Or was prescribing it the responsibility of the Mental Health Outreach Team, as we were told by the Head of Health Care at Brixton was the policy in place at the time? Or was it a matter for the

Substance Misuse Team which had regular contact with AC and other dual diagnosis cases and which included psychiatrists among its staff?

During the investigation it became clear to us that not only did a disagreement exist in 2010 with disastrous consequences for AC, but that such a disagreement still exists at the time of finalising this report. This appears to be a potentially serious problem which may threaten the wellbeing and even the safety of prisoners at HMP Brixton. It was recommended in the report of the investigation carried out by Care UK in 2010 that “roles and responsibilities between professionals in different teams must be clarified and documented”²²⁶. Key recommendation number one in the report of an investigation by SLaM in 2011 was “to clarify who is responsible for prescribing medication for any prisoner who has previously been prescribed medication in the community”. This Article 2 Investigation has found that these recommendations have not been taken on board. A public hearing would be able to establish why a systemic failing uncovered soon after the incident of life-threatening self-harm has not been put right.

There is a further question that also requires further scrutiny. This relates to Finding Fifteen:

There is a potentially important discrepancy between what was told by Nurse C to the Care UK investigation and to us about whether he thought AC was subject to an ACCT when he saw him on 24 May.

The issue here is that Nurse C, from the Mental Health Outreach Team, told us that he did not consider AC to be at risk of self-harm and suicide when he saw him on 24 May 2010, eleven days before the incident of life-threatening self-harm. Indeed, the record of the assessment notes that AC “currently denies any DSH [deliberate self-harm]/suicide ideations”.²²⁷ It appears, however, from the investigation into the case carried out by Care UK that the nurse told them that the patient was “appropriately managed on ACCT on wing as a precaution for individual who appeared at risk”. ACCT (Assessment, Care in Custody and Teamwork) is a care-planning system for

²²⁶ SLaM report, page 4. Annex D

²²⁷ Medical Record Printout, 24 May 2010, entry by Nurse C. Annex F

prisoners considered to be at risk of self-harm or suicide. Despite assiduous efforts, we have not been able to obtain the statement of the nurse's interview with the Care UK investigation so it is not clear to us exactly what he said.

What is clear is that AC was *not* in fact subject to an ACCT. But the independent Article 2 Investigation is puzzled as to why the nurse told the Care UK investigation that AC was subject to an ACCT when he was not. If the nurse held the view at the time he was assessing AC on 24 May 2010 that AC was subject to a monitoring and care-planning system on the wing, this might have affected the urgency that he attached to the plans for addressing AC's mental health care needs. Alternatively, the nurse may have known on 24 May 2010 that AC was not subject to ACCT but may have made a mistake when giving evidence to the Care UK investigation. A public hearing might establish which of these two scenarios is most likely.

In the light of these two findings and the questions which they raise, I consider that a greater level of public scrutiny is required than that provided by the publication of this report alone.