CASENOTES
PRISON DEATHS

BRENDAN FLYNN

Inquest into the death of Brendan Flynn

By Anna Crawford and Nick Armstrong

Name of deceased: Brendan Flynn
Place of death: Segregation Unit, HMP Wakefield
Date of death: 11 August 2004
Date of inquest: 11-29 May 2009
Coroner: HM Assistant Deputy Coroner for West Yorkshire (Eastern District), Ms Melanie Jane Williamson
Verdict: Narrative verdict
Solicitor: Daniel Machover and Anna Crawford, Hickman & Rose Solicitors
Counsel: Nick Armstrong, Matrix Chambers

The inquest examined the treatment of newly-sentenced prisoners, the quality of medical assessments, and the adequacy of night time unlock policies in emergencies. Other parties represented were the Prison Service and Mr Danny Alba, who had conducted the clinical review for Wakefield West Primary Care Trust.

Background

On 11 August 2004 Brendan Flynn was found hanging in his cell on the segregation unit of HMP Wakefield just after midnight. Mr Flynn was 28 years old.

On 4 August 2004 Mr Flynn was sentenced to twenty years imprisonment, and during the period from 6 to 9 August 2004, various prison officers documented that Mr Flynn was shocked and depressed about the length of his sentence.

On 10 August 2004 Mr Flynn was taken to segregation for two adjudications. He was assessed by a nurse and a locum doctor who confirmed that he was fit for adjudication and cellular confinement. Mr Flynn received seven days cellular confinement and was placed in a cell on the segregation unit.

Mr Flynn was subjected to hourly checks, due to his category A status. At 23:01 a segregation officer made the last recorded check whilst Mr Flynn was still alive. At 00:01 the same officer returned to carry out the next check and saw Mr Flynn hanging.

The officer kicked the door and shouted but did not gain a response. He returned to the wing office and rang for backup. At 00:08 the segregation officer and three other members of staff entered Mr Flynn' cell. Their attempts to resuscitate him were unsuccessful and Mr Flynn was pronounced dead at 01:10.

The inquest

Unlock policy and procedures

The policy that HMP Wakefield had in place at the time provided that category A prisoners could not be unlocked at night unless there were three prison officers, a manager and a dog present. However, the jury heard that the segregation unit is staffed by only two prison officers during the night. A combination of these factors meant that prison staff did not enter Mr Flynn's cell for over seven minutes after he was first discovered hanging.

In *Keith Lewis v HM Coroner for the Midland North Division of the County of Shropshire and the Secretary of State for Justice* [2009] EWHC 661 (Admin), the court upheld as article 2 compliant the coroner's decision not to leave a question to the jury about the period after the deceased was found hanging on the basis that: (i) there was no evidence upon which a reasonable jury could conclude that the actions of the prison officer who discovered him had *"caused or contributed"* to the death; and (ii) the jury had no jurisdiction to consider factors which had not *"caused or contributed"* to the death.

In this case, the prison officer who discovered Mr Flynn was asked whether he thought that Mr Flynn may have been alive at the point that he found him hanging. In evidence the officer said that in his opinion, it was possible that Mr Flynn was not dead at the time that he initially found him.

On the basis of the officer's evidence, and despite the lack of any medical evidence regarding time of death, the coroner accepted the family's submissions that this case could be distinguished from *Lewis* because the oral evidence given by the prison officer that it was possible that Mr Flynn was not dead when he discovered him, was evidence upon which a reasonable jury could conclude that the actions of the prison officer had "caused or contributed" to the death.

In their narrative verdict the jury found that, "in an emergency situation we felt that a minimum of two officers would have been sufficient to open Brendan's cell door, once the night orderly officer was informed; therefore the requirement as to staffing levels was too cautious."

Failure to place Mr Flynn on a suicide and self-harm form

The policy in place at HMP Wakefield at the time of Mr Flynn's death provided that category A prisoners receiving life sentences should be placed on a suicide and self-harm form (the F2052SH at that time).

The Prisons and Probation Ombudsman recommended that the prison consider extending the policy to prisoners, such as Mr Flynn, who had been newly sentenced to long determinate sentences.

At the inquest a governor gave evidence that HMP Wakefield had decided not to extend the policy to newly-sentenced prisoners with long determinate sentences because procedures had changed as a result of the introduction of ACCT (Assessment, Care in Custody, and Teamwork), which is intended to be less process-driven and a more individualised process. The >>

>> Governor also said that as a result of the introduction of ACCT the prison no longer had a policy of automatically opening suicide and self-harm forms for prisoners newly sentenced to life imprisonment.

In their narrative verdict, the jury found that Mr Flynn should have been on a suicide and self-harm form because of the way he was presenting to staff. They also found that "newly long determinate sentenced prisoners should automatically be placed on a F2052SH." The coroner also made a similar rule 43 recommendation.

Adequacy of medical assessments

On 10 August 2004 Mr Flynn was seen by a health care officer who confirmed that he was fit for adjudication. He was subsequently seen by a locum doctor who confirmed that he was fit for cellular confinement.

The jury viewed CCTV footage which showed that the doctor's visit only lasted for 34 seconds. The doctor who carried out the assessment is now deceased, and so the jury were unable to hear evidence from him. However, another prison doctor from HMP Wakefield gave evidence that an assessment in these circumstances should usually take about fifteen minutes, although it could be longer if a more detailed assessment was considered appropriate.

The Prison Service sought to prevent a question being left to the jury regarding the adequacy or otherwise of the doctor's medical assessment, submitting that any failing did not cause or contribute to Mr Flynn's death. This submission was based on the evidence given by a prison doctor from HMP Wakefield referred to above, who gave evidence as to what questions he would ask during a longer assessment but stated that in his opinion, a longer assessment would not have revealed more information about Mr Flynn's state of mind, and that in his experience longer assessments did not make any difference.

The Prison Service submitted that a question regarding the adequacy of the assessments was a medical question and that the only medical evidence that had been heard on the issue suggested that a longer assessment would only have made a minimal difference. In response, the family submitted that the question was in fact a mixed question. The prison doctor had given evidence regarding what questions would be asked during a longer assessment, and the jury could properly decide what answers that might produce from all the surrounding evidence. The coroner accepted this submission and left the question to the jury, which found that the medical assessments were inadequate.

Verdict

The jury produced a narrative verdict, which included the following:

1. Mr Flynn hanged himself whilst the balance of his mind was disturbed;
2. The lack of a radio and reading material in his cell contributed to his state of mind;
3. Two prison officers would have been sufficient to open Mr Flynn's cell when he was discovered hanging. The rule requiring three prison officers, a manager and a dog to open the cell was too cautious;
4. Mr Flynn should have been automatically placed on suicide watch as a newly-sentenced prisoner on a long determinate sentence;
5. Mr Flynn should have been placed on suicide watch in any event after reporting to prison officers that his head was a mess;
6. The medical assessments carried out on Mr Flynn were inadequate;
7. Staff received inadequate, insufficient and inconsistent suicide awareness training.

Comment

Mr Flynn's family were distressed that prison documentation had been tampered with following his death, and that the prison had failed to retain vital evidence.

At the inquest a prison officer admitted falsifying a local Behavioural/Activity Risk Assessment Record (BARAR) following Mr Flynn's death. The officer had completed the form the day after Mr Flynn's death and backdated it to the day before the death. The jury also was unable to view vital CCTV footage of the thirty minutes before Mr Flynn was discovered hanging as the prison had failed to retain it due to a technical error in downloading the footage.

The CPS is reviewing its earlier decision not to prosecute the prison officers involved in the falsification of the BARAR form.