

A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

---

**Investigation into the death of a man in October 2014  
at HMP Brixton**

## ***Our Vision***

*To be a leading, independent investigatory body,  
a model to others, that makes a significant contribution to  
safer, fairer custody and offender supervision.*

This is the investigation report into the death of a man, who was found hanged in his cell in October 2014, at HMP Brixton. He was 51 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received at HMP Brixton was undertaken. The prison cooperated fully with the investigation.

The man had been at Brixton since 29 July, serving a 12 month sentence. He had been in prison before. He had mobility problems and suffered from anxiety and low mood. He had previously had pancreatitis caused by excessive alcohol consumption. On 11 August, he said that he might kill himself and a substance misuse worker started suicide and self-harm support procedures, which continued until his death.

The man often said he felt suicidal, either because of anxiety or stomach pains. His pain was not constant, but he sometimes said he was in agony. In the early hours of 9 October, he cut himself and was taken to hospital. He said he wanted to die. Later that morning when he was back at the prison, staff assessed his risk of suicide and self-harm as high, but did not increase the frequency of his observations. On 10 October, he told an occupational therapist that he did not think he would make it through the weekend and she referred him to a psychiatrist, but did not let wing staff know what he had said. That evening, staff moved his cellmate to another cell, leaving him on his own. A prisoner warned an officer that he thought the man would harm himself. The officer did not record this or tell anyone else. After lunch, an officer unlocked his cell and found he had hanged himself. Staff attempted resuscitation and paramedics arrived quickly, but were unable to save him.

Brixton provided some excellent psychosocial and resettlement support for the man. However, the root cause of his pain was not sufficiently investigated and I agree with the clinical reviewer that the overall standard of healthcare he received was not equivalent to that he could have expected in the community. Similarly, although staff rightly identified that he was at risk of suicide and self-harm, I am concerned that there were serious weaknesses in the prison's suicide and self-harm prevention procedures, including insufficient healthcare involvement, poor communication about significant events and inadequate assessment of risk. After his death, some prisoners alleged that a member of staff had spoken inappropriately to him, not long before he died. The prison assured us that they would investigate these allegations but I am not satisfied that an appropriate investigation took place.

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

## **CONTENTS**

Summary

The investigation process

HMP Brixton

Key events

Issues

Recommendations

## SUMMARY

1. The man arrived at HMP Brixton on 29 July. A nurse noted that he had previously had pancreatitis, had a neurological disorder because of alcohol abuse and used a walking frame. He was taking anti-depressants.
2. On 11 August, a member of the substance misuse team began suicide and self-harm support measures (known as ACCT), because the man was tearful and low in mood. Staff continued to manage him under ACCT procedures for the rest of his time at the prison. He often complained of stomach pain, which appeared particularly severe on 8 October. A doctor thought his pain had psychological causes.
3. Early on 9 October, the man was treated in hospital for a self-inflicted cut to his hand and said he wanted to die. Staff increased his risk of suicide and self-harm to high, but did not change the frequency of observations. On 10 October, he told an occupational therapist that he would not make it through the weekend and would kill himself because of his stomach pain. He later told a psychiatrist that he had harmed himself because of his stomach pain, but now felt better. Neither the occupational therapist nor the psychiatrist passed any information to wing staff or recorded their contact with him in the ACCT document. He had often said that his stomach pain was the cause of his depression and the reason that he self-harmed, but staff did not record this as a risk factor. On the evening of 10 October, staff moved his cellmate, leaving him alone in the cell. No one recorded the reason or considered how this might affect his risk.
4. In the morning, a prisoner told an officer that he thought the man was going to harm himself and he needed closer monitoring. The officer did not alert other wing staff or record this in the ACCT document. (After his death, other prisoners alleged that he had told a supervising officer that he would kill himself because he was not receiving the right medication, and she had told him to go ahead.)
5. An officer unlocking the man's cell after lunch found his cell door barricaded and saw him hanging. He radioed for help but did not use an emergency code. He and another officer broke the barrier into the cell. Healthcare staff and paramedics attempted resuscitation, but, at 2.25pm, paramedics pronounced him dead.
6. The clinical reviewer found that communication between healthcare staff was poor, which meant the man's standard of care was not equivalent to that he could have expected to receive in the community. He noted that while he had pancreatitis, healthcare staff had found it difficult to diagnose because his symptoms were atypical. Nevertheless, healthcare staff should have investigated his pain further. We found serious failings in the operation of ACCT procedures. Important information about his risk was not communicated effectively and the level of observations was not adjusted to reflect his assessed risk. Although this caused only a slight delay, the officer who found him did not use the appropriate emergency code. The prison did not debrief the staff in line with national instructions and did not investigate appropriately, serious allegations made by several prisoners about the conduct of a supervising officer. We make five recommendations.

## THE INVESTIGATION PROCESS

7. We issued notices to staff and prisoners at HMP Brixton informing them of the investigation and inviting anyone with relevant information to contact one of the investigators. Initially, no one responded. Subsequently, a prisoner who was released from Brixton during the investigation contacted us and said that he had information. Unfortunately, the telephone number he left was unobtainable. We left a message with his solicitors but we have not been able to make further contact. Two other prisoners wrote to us about the circumstances of the man's death.
8. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison record. He and another investigator interviewed 16 members of staff at the prison in December and one prisoner.
9. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.
10. We informed HM Coroner for Inner South London District of the investigation, who provided the post-mortem report. We have sent the coroner a copy of this investigation report.
11. One of the Ombudsman's family liaison officers wrote to inform the man's next of kin of the investigation. We received no response.
12. The man's next of kin received a copy of the draft report, but have raised no factual inaccuracies and have not commented on the findings.

## **HMP BRIXTON**

13. HMP Brixton is a resettlement prison, which holds over 800 men. Care UK coordinates healthcare services at the prison, with a number of different providers. A GP service runs from 8.00am until 5.00pm on weekdays. Nurses are on duty between 7.00am to 7.30pm daily.

## **HM Inspectorate of Prisons**

14. The most recent inspection of HMP Brixton was in July 2013. The Inspectorate found that health services were generally good. External appointments were well managed and coordination between providers effective but chronic disease management was poor. Inspectors noted that insufficient attention was paid to vulnerability and safety issues and too few staff were trained in suicide and self-harm awareness. However, levels of self-harm were low and those at risk felt well supported.

## **Independent Monitoring Board**

15. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its most recently published report for the year to 31 August 2014, the IMB noted that the prison was generally calm but that staffing levels were inadequate to run the prison safely and humanely. They reported that the needs of prisoners with disabilities were often not addressed, and highlighted one incident in February 2014 when a request for an emergency ambulance was not acted upon for 20 minutes. Overall, the IMB considered that healthcare provision was adequate.

## **Previous deaths at HMP Brixton**

16. The man's death is the third self-inflicted death at Brixton since 2012. We have previously made recommendations about ACCT procedures which were accepted by the prison, including the need for staff to consider risk factors and triggers for self-harm fully and follow Prison Service instructions for ACCT procedures. We also recommended the prison should use a recognised medical emergency code system.

## **ACCT - Assessment, Care in Custody and Teamwork**

17. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be irregular to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves drawing up a care map to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all of the actions on the care map have been completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

## **KEY EVENTS**

### **HMP High Down**

18. On 28 April 2014, the man was remanded to HMP High Down charged with unlawful wounding and damaging property. He had been in prison before. At an initial health screen, a nurse noted that he used a walking frame to help him get about, but did not have a diagnosed disability. He had previously had pancreatitis, caused by excessive alcohol use. The nurse noted that he needed to detoxify from alcohol. (He subsequently completed a detoxification programme.) She noted that he had harmed himself three years previously, by taking an overdose of prescribed medication. He said that he had no current thoughts or plans to harm himself, although he was anxious about his situation. A doctor assessed him and prescribed a low dose of anti-depressant medication to help his anxiety.
19. On 29 May, the man was convicted and sentenced to 12 months imprisonment. At court, he said he had suicidal thoughts and intended to tie a bed sheet around his neck. Escort staff recorded this on his escort record and reception staff at High Down began ACCT suicide and self-harm prevention procedures. Staff managed him under ACCT procedures until 8 June, when he seemed more positive and said that he had no further thoughts of harming himself.

### **HMP Brixton**

20. On 29 July, the man was transferred to HMP Brixton as a routine move. A nurse assessed him when he arrived and reviewed his medical records from High Down. The nurse recorded that he had no thoughts or feelings of self-harm, was on anti-depressant medication and had completed an alcohol detoxification at High Down.
21. The next day, a prison doctor saw the man and noted his previous misuse of alcohol. He said his eyesight and hearing were getting worse. The doctor referred him to a neurologist because he said that he suffered from neurological problems, as a result of alcohol misuse, which caused his mobility problems.
22. On 11 August, a member from the substance misuse team assessed the man because of his alcohol problems. The member recorded that the assessment was difficult and the man was tearful and low in mood. He told the member that he was feeling hopeless and suicidal and the member referred him to the Improving Access to Psychological Therapies team. (The Improving Access to Psychological Therapies (IAPT) programme supports the frontline NHS in implementing National Institute for Health and Clinical Excellence (NICE) guidelines for people suffering from depression and anxiety disorders. It offers talking therapies and supported self-help combined with medication, where appropriate). The member opened an ACCT document and recorded that the man had said that he might kill himself with a razor or by hanging himself.
23. Later that day, an officer completed an ACCT assessment and noted that the man had said that he had no current thoughts of self-harm, but he felt low. He was depressed and anxious about what would happen when he was released in October 2014. He said that he felt vulnerable because of his mobility problems.

24. Immediately after the assessment, a Supervising Officer (SO) and an officer held an ACCT case review. There was no member of healthcare staff present. The SO discussed the man's concerns with him and recorded on an ACCT caremap that his issues were feeling depressed, his accommodation after he was released and his dog dying. Staff referred him to relevant agencies to help with his housing. The SO noted that he was currently receiving medication for depression.
25. The SO recorded the man's level of risk of suicide and self-harm as low, and required staff to observe him once an hour when he was in his cell and to make at least one meaningful entry in the ACCT document on the morning, afternoon and evening. The SO set the next review for 19 August, and noted that a member of the mental health team should attend.
26. The next day, 12 August, a SO and a wing officer held another ACCT case review. The SO could not recall the reason why this had been brought forward, but thought that someone had told her the man was frustrated because he had been offered an education place, but his mobility difficulties meant he could not get to the third floor, where the course was held. They agreed that he should have alternative activity in the textiles workshop and he started a fashion course the next day. She said that as he was subject to ACCT monitoring she had recorded her discussion with him as an ACCT review. No one from the mental health team attended.
27. The SO recorded on the man's record and on his ACCT document that he was negative in his thoughts and was suffering from depression for which he was on prescribed medication. She set the date for the next review as 24 August. His perceived risk of further self-harm remained the same. She made no changes to the level of observations or the caremap.
28. Some of the man's anxieties were about losing his home and the assistance he would get when he was released from prison. On 13 August, a member of the substance misuse team contacted a residential treatment centre to see if the man could apply to go there when he was released.
29. Later that day, a member from the mental health team assessed the man's mental health. He recorded an in-depth social history and completed a Patient Health Questionnaire 9 (PHQ9, used to monitor the severity of depression or response to treatment). The man scored 21 and the member noted from this that he could be severely depressed.
30. The member told investigators that the man appeared very sad and subdued about being back in prison. He said that the man was concerned about losing his home and seemed very isolated. Although he knew prison routines well, he appeared quite vulnerable. He said that he thought the man felt more vulnerable because he used a walking frame. He planned to discuss him with the wider mental health team, refer him to the Improving Access to Psychological Therapies (IAPT) team again and liaise with his substance use worker about the support that other agencies could offer.
31. On 14 August, an assistant psychologist from IAPT assessed the man. He said he did not get on with his cellmate and that he had no current thoughts of self-

harm. He said his protective factors were his sister, his faith, and the hope that he would be able to go into rehab after he was released. He said that he found being managed under ACCT procedures difficult, as staff checked him frequently. He said that he wished he had not said anything about how he was feeling. He said that he had just wanted the best support that he could get at the time and felt that disclosing his suicidal thoughts would help. She planned for him to receive cognitive behavioural therapy (CBT) and placed him on the waiting list for counselling.

32. Substance misuse staff, IAPT staff and mental health team staff assessed and reviewed the man frequently. He obtained a place in a residential rehabilitation unit for after his release, but he said that he still felt anxious about being released from prison. He was referred to an occupational therapist to assess his physical needs because of his mobility difficulties.
33. On 22 August, a SO chaired an ACCT review, which the member from the substance misuse team attended. The SO recorded that while the man still felt depressed, he was attending the fashion course and keeping himself active. The SO wrote that the ACCT would remain open to allow him time to work on his coping skills. The level of observations remained the same and his risk of suicide and self-harm was recorded as low. Nothing was added to the caremap.
34. On 4 September, the man told a member from the IAPT team that he had thoughts of hanging himself because he felt intimidated by staff and other prisoners due to his disability. He said that it would help if he had a cellmate who was closer in age and who would collect his meals for him. She informed the wing manager, who held an ACCT review which the members from the mental health and IAPT teams attended. He said that he felt better after speaking about his concerns and the SO recorded that they would move his cellmate and identify someone similar in age to share with him. The SO told him that, although he would still need to go to the hotplate at mealtimes to confirm his meal choice, they would ask a member of staff or a prisoner to carry meals back to his cell for him. The SO set the next ACCT review for 11 September. The frequency of observations and his perceived level of risk remained the same.
35. On 11 September, a SO chaired the ACCT review, which the member from the IAPT team also attended. The SO recorded that the man said that he still felt depressed because he was unsure about the living plans made for after he was released would be suitable. He was taking his medication regularly. The review made no changes to the frequency of observations or his perceived level of risk. The SO scheduled the next review for 21 September.
36. On 12 September, the occupational therapist met the man for the first time. He completed a self-assessment and spoke about how his disability affected him. She told investigators that the mental health team had referred him so she could assess his physical difficulties and what adaptations and support he might need after release.
37. On 22 September, a SO chaired an ACCT review, attended by members from the IAPT and substance misuse teams. The SO told investigators that they had spent at least an hour with the man. Although the substance misuse team

member gave him positive news about his housing options after release, the SO said that the man kept looking for reasons why things would not work. She said that in her opinion he was not willing to take responsibility and was negative about his future, despite the work the member of the substance misuse team was doing for him. The review agreed that he should continue to be supported by an ACCT and made no changes to the frequency of observations. The SO did not review the care map or update it to include his housing concerns and the actions being taken. She scheduled a further review for 6 October.

38. On 3, 4 and 5 October, the man saw three different nurses and complained of abdominal pain. The nurses diagnosed him with indigestion and prescribed antacid medication to relieve the symptoms. On Monday 6 October, he told a nurse that he still felt ill and had been having constant abdominal pain for the past four days, which was worse at night. He said that the pain was similar to the pancreatitis he had previously had. She noted that he had been prescribed paracetamol and antacid medication over the weekend, but this had no effect and referred him to the doctor.
39. On 6 October, a SO and a substance misuse worker held an ACCT review. The SO recorded that the man was optimistic about his forthcoming release from prison on 27 October. However, he had said that he was concerned about his stomach pain and was waiting for a doctor's appointment. He said that he had no thoughts of self-harm, but the staff agreed to continue the ACCT until he was released. They did not change the frequency of observations and still assessed his level of risk of suicide and self-harm as low. The SO scheduled the next review for 13 October.
40. The SO told investigators that several agencies had helped with the man's drug, housing and mental health issues, and that the substance misuse worker had done a lot of work to get supportive housing and a place in a rehabilitation programme for him. The SO thought that he seemed quite upbeat during the review and did not appear to be in discomfort or pain.
41. On 7 October, a doctor examined the man, who said that he had been suffering from abdominal pain for five days, but did not feel sick. The doctor prescribed more indigestion medication. He told the investigators that he did not identify anything significant when he examined him and that he seemed happy with the diagnosis and knew to come back if the pain persisted.
42. Later that day, the mental health worker recorded that when he spoke with the man, he was negative in outlook. He told investigators that the man described his stomach pain in a way that suggested hyperacidity or perhaps gastric reflux. He said that the man smoked and had a history of alcohol abuse, so such problems would not be unusual. He said that the man believed the pain was more than indigestion, but had not been specific about what he thought it was.
43. Just before 9.00am on 8 October, a nurse examined the man in the wing treatment room as he was unwell. She said that he was in agony and complained of excruciating abdominal pain and said he was dizzy. His blood pressure was raised. He said that he wanted to die and could not cope any longer. She said she spoke to the doctor, who told her that he had seen him the previous day. She asked the doctor to see him again or prescribe stronger

pain medication. He prescribed 60 milligrams of nefopam (a strong painkiller) but did not see him. She said that she spent around 45 minutes with him and sent a note on the SystmOne electronic medical record to the mental health team informing them about his comment about wanting to die.

44. The nurse said that the man calmed down once he had taken medication and she took him back to his cell. She said that she told two wing officers that he had said he wanted to die and she asked if he was being managed under ACCT procedures. (He did not have an ACCT document with him.) The officer confirmed he was, and told the nurse that she should make an entry in the ACCT document, which she did.
45. The nurse told investigators that she went to speak to the wing manager, but an officer told her that the manager was not there. She asked the officer to pass on a message about the man, but the officer said that if she had already told wing staff then she 'had done her job'. She told investigators that before she left the wing she established that he had a cellmate and when she looked into his cell he looked relaxed and was talking to his cellmate. No one held an ACCT review to consider whether his comments had increased his risk.
46. A mental health worker went to see the man later that day, after seeing the nurse's message to the mental health team. However, he was sleeping at the time so he did not wake him. The worker told the investigators that he had discussed him with a doctor, who told him he had prescribed different medication to alleviate his stomach pain. The worker said that he was content that the GP had taken some action to deal with the man's pain.
47. At 3.08am on 9 October, the man's cellmate pressed his cell bell and told an officer that the man had cut his left hand and had said that he wanted to die. A nurse gave initial treatment and he was taken to hospital for further treatment. The man told the escort officers that he was depressed and they noted that he had had said that he had previously, but unsuccessfully, attempted to harm himself (he did not say how or when). After hospital staff had treated the wound, officers brought him back to the prison and returned him to his cell. Despite his act of self-harm, no one reviewed the frequency of observations or considered whether his level of risk of suicide or self-harm had increased.
48. On the morning of 9 October, staff discussed the man at a wing meeting and immediately afterwards the Head of Safer Custody and Equalities and a SO held an ACCT review. The Head told investigators that he had learnt of the man's self-harm the previous night, and wanted to ensure a review was held, so he had gone to A Wing, where he lived, shortly after he arrived for duty. The SO had suggested they held the review immediately as the man had a medical appointment later that morning. There was no member of healthcare staff at the review.
49. The Head said that the man had told him that his main problem was his stomach pain. He could not recall the reason the man had given him for self-harming, and this was not noted in the record of the review. He said that he did not think that the man had seemed suicidal, but he had spoken about his worries about his release. He and the SO assessed the man's risk of further suicide or self-harm as high, but did not change the frequency of observations, which remained at once an hour when he was locked in his cell.

50. The Head told the investigators that he believed he had assessed the man as at high risk because of his recent self-harm, but could not be sure as he had not written the notes of the review. With hindsight, he said they should have increased the frequency of observations.
51. The SO told investigators that he attended the review, as he knew the man and they often spoke on the wing. The SO said that the Head chaired the review and, despite his recollection, it was the Head who had written up the record of the review in the ACCT document. The SO said that they would have discussed the level of risk during the review. He could not recall if they decided to change the level of observations, but thought that this would have been the Head's decision.
52. A doctor and a mental health worker also saw the man on 9 October. He told them that he had cut himself because he was fed up with prison. The doctor noted in the medical record that he did not seem to be in pain but was low and tearful. The doctor concluded that he did not have any obvious abdominal problems and that his problems were mental rather than physical. He noted that he should see the psychiatrist. The mental health worker made a note of their consultation in the ACCT document.
53. A SO told investigators that, on the morning of Friday 10 October, night staff reported to her that the man had been complaining of stomach pain throughout the night and had kept his cellmate awake. (This was not recorded in his ACCT document.) She told investigators that his cellmate told her that he had been kept awake for 10 nights in a row because of his pain. She said he did not appear to be in pain, but she took him to the treatment room to see a nurse. The nurse told her that healthcare staff were aware of his problems and that a doctor and someone from the mental health team were going to see him later that day. She said that she had told him that if he did not feel that he was getting anywhere then he should speak to her again.
54. Later that morning, the man attended an appointment with the occupational therapist for an assessment to see what physical aids he needed as part of his support on release. She noted that he appeared very distressed and said he had stomach pain. They discussed his alcohol rehabilitation and plans for his release. She told the investigators that he was mostly concerned with his stomach pain rather than his mobility problems. He said that the pain in his stomach was so bad he did not think he would make it through the weekend without help, and that he would kill himself.
55. The occupational therapist said that she spoke to a doctor, who told her that he considered the man's pain was linked to his psychological needs. She asked what she could do to ease his pain and he suggested that a nurse should take his clinical observations to see if there was anything to indicate a physical problem. She arranged for a nurse to take his observations (pulse, temperature, blood pressure), which were all within normal ranges. She said that she had left him with the nurse while these observations were completed and attended the morning mental health meeting. She mentioned him at the meeting and was told that the psychiatrist would be seeing him that afternoon.

56. The occupational therapist told the investigators that she had not recorded her concerns about the man and what he had said about taking his own life in his ACCT document, as it was not with him (as it should have been). She noted the information in his medical record, but nowhere else where wing staff would have had access, such as in his individual record. She said that she had not contacted the wing or gone there to make an entry in his ACCT record as she had decided to wait for the outcome of his appointment with the psychiatrist. She told the investigators that she was aware of ACCT procedures and had attended foundation level ACCT training.
57. A visiting psychiatrist assessed the man on the afternoon of 10 October, accompanied by a member of the mental health team and the occupational therapist. He told the investigators that the occupational therapist had informed him that the man had been expressing suicidal thoughts and complaining about ongoing stomach pain, which painkillers were not controlling. The occupational therapist had told the psychiatrist that the man had said that he would not survive the weekend, which the psychiatrist thought referred to both the physical pain and the risk of him taking his own life.
58. The psychiatrist said that he noted that the man had slight difficulty in walking and used a frame, but he sat down comfortably on the chair. He said the man had talked openly about his problems and said that he had harmed himself because he could no longer stand the pain in his stomach. He thought that the man appeared slightly anxious, but found no evidence of any major depressive or psychotic illness. He said that the man did not talk about any plans to harm himself, but said that he was unhappy with the doctor's diagnosis as he thought that his history of pancreatitis was not being considered. He said he wanted a hospital referral.
59. The psychiatrist told the investigators that he saw nothing to indicate that the man was in pain and he did not think that he needed to overrule the doctor's opinion. He said that he had received foundation level ACCT training. He did not record anything about the consultation in the ACCT document and neither did the occupational therapist or the mental health worker.
60. The man's cellmate moved from their cell around 5.30pm on 10 October. We were given different reasons for the move. A SO said that during the afternoon of 10 October, Officer A, from A Wing phoned her and said that his cellmate had asked to move. She said that she had told the officer that the duty manager would need to agree a move, as he was being monitored under ACCT procedures and should not be in a cell on his own.
61. Officer A said that, when staff had unlocked the wing on 10 October, the man's cellmate was very distressed and had spoken to the SO immediately. She said that the SO had told her that she wanted his cellmate moved to a different cell.
62. Officer A said that the SO did not ask her to find another cellmate. She had tried to find a cellmate nearer to his age, as this had previously been an issue for the man. However, there was no one suitable and no one would volunteer to move. She did not record his cellmate's move or what she had done in his record, ACCT document or the wing observation book. She said that before she left she asked the night officer to watch him, who was now by himself in the cell. She did not record this. She said that she had tried to contact the duty

manager, but had been unable to do so because the manager was not in the central office when she called, and she then moved on to other tasks. His ACCT observations remained unchanged.

63. Three prisoners said (after the man's death) that on the morning of his death, he told a SO that he would kill himself if his medication was not sorted out. The prisoners alleged that she told him to go and do it as she did not have time for him. One of the prisoners claimed that she said "I have better things to do than listen to idiots".
64. The SO told investigators that she was managing A and B Wings that morning and had spent very little time on A Wing as she was dealing with problems on B Wing. She said she had not interacted with the man at any point that morning.
65. The man's personal officer noted in his ACCT document that morning that he had told him he was concerned about his stomach pains and hoped to go for an X-ray. Despite recording this, the officer told investigators that he could not recollect speaking to him that morning.
66. Prisoner A, a friend of the man's, said that the man had told him that morning that he had had enough and would end up hurting himself. He lived on a different landing and, as he went upstairs to go back to his cell later that morning, he told an officer that he was concerned about him and that someone should keep an eye on him. He said that the officer told him to leave it with him.
67. The officer said that the prisoner had raised concerns about the man with him, but he said that he had told him to tell an officer on the man's landing, as he was busy. He said that he had no immediate concerns and had seen the man walking around that morning and he appeared to be fine. He did not record in the ACCT document what the prisoner had told him and did not tell other staff.
68. On Saturdays, staff issue shop orders to prisoners during the morning. Prisoners usually collect their lunch between 12.00 to 12.30pm and staff then lock them in their cells until 1.45pm, when they are unlocked for an afternoon association period. The staff lunch time is usually between 12.30pm to 1.30pm. Officers said that there was a delay on A Wing that day, which meant that staff went for lunch later than normal, although there is no record of the exact time.
69. At 1.00pm Officer A recorded in the man's ACCT document that he had no issues and was watching television at the time. He told the investigators he could not recall completing this check.
70. At approximately 2.30pm, staff began unlocking prisoners for the afternoon association period. When Officer A unlocked the man's cell he found the door was blocked from the inside and he was unable to open it. He looked through the observation panel and saw him hanging by a torn bed sheet attached to the window bars. He told the investigators that he shouted to other officers on the wing and also radioed for help.
71. In line with national instructions, Brixton has a two tier emergency medical code system. Code 1 indicates that a prisoner is unconscious or has breathing difficulties and Code 2 is used for other serious injuries. The national

instruction and Brixton's local protocol requires the control room to call an emergency ambulance immediately when either code is used. Officer A was unclear whether he had used an emergency code. The control room records show that they received a radio call stating that a prisoner was 'hanging' at 2.39pm, but no code was given. Ambulance service records show that they received a call at 2.42pm.

72. Officer B was the first to respond to Officer A's call for help. He was on the landing above, when he heard him shout that someone was hanging. The two officers pushed at the door to try to get in, but the door was blocked by a bedside locker. With considerable effort, the officers managed to get into the cell and Officer A supported the man's body while Officer B cut the sheet by which he was hanging.
73. Nurses recorded that they had received a call for medical assistance at 2.39pm and arrived on A Wing just before both officers got into the cell. Officer B began cardiopulmonary resuscitation while nurses assessed the man. Nurses then took over resuscitation. They attached a defibrillator to him but found no shockable heart rhythm. Paramedics arrived on the wing at 2.47pm and took over emergency treatment, but at 2.55pm, pronounced him dead.
74. The then Governor of Brixton went to the man's sister's home and informed her of her brother's death, at 5.30pm. He told her that the prison family liaison officer would phone her, which he did on 13 October, to offer support. A memorial service was held within the prison and, in line with national guidelines, the prison contributed to the cost of the funeral.

### **Support for Staff and Prisoners**

75. At 6.30pm on 11 October, an operational manager held a 'hot' debrief for the staff involved in the emergency response, but Officer A and B had left the prison before then. The staff who attended said they felt well supported. Members of the care team and the IMB visited A Wing after the man's death and spoke to staff and prisoners, including his former cellmate and Prisoner A and offered them support. The prison did not hold a critical incident debrief later, which several members of staff said they would have found useful.

### **Post-mortem**

76. A post-mortem examination confirmed that the man had died from suspension. The pathologist also found that he had acute chronic pancreatitis, which was likely to have caused him severe pain.

## ISSUES

### Clinical care

77. A clinical reviewer reviewed the standard of healthcare the man received at Brixton. He concluded that Brixton provided excellent psychosocial support for the man, particularly in relation to his occupational therapy and counselling for alcohol problems and mental health support. However, his general standard of clinical care was inconsistent and not equivalent to that he could have expected to receive in the community.
78. The post-mortem examination found that the man had acute chronic pancreatitis and the clinical reviewer considered whether doctors at Brixton should have diagnosed this. He noted that the man had a history of recurrent pancreatitis and had said that the abdominal pain he had experienced in the days before his death was comparable to the pain he had experienced previously with an attack of pancreatitis. However, in other respects, the man's reported pain was not consistent with the acute abdominal pain associated with pancreatitis. He appeared to have relatively short-lived periods of pain, punctuated by periods where he appeared to be comfortable and almost pain-free, whereas a patient with acute abdominal pain, including pancreatitis, would usually experience an inexorable decline.
79. The clinical reviewer noted that a doctor undertook a comprehensive assessment of the man on 7 October and found no signs of acute abdominal pain. He reviewed him again on 9 October, but he appeared relatively free of pain. He went to hospital after cutting himself on 9 October, but hospital staff there did not note acute pain. When the psychiatrist saw him on 10th October, he was comfortable and did not display signs of acute physical distress. The clinical reviewer concluded that, although the diagnosis of pancreatitis was missed, this was understandable because of the atypical presentation and his complex circumstances.
80. However, the clinical reviewer also noted that the man experienced an increase in physical and mental distress in the days leading up to his death. He considered that these were not dealt with effectively because the healthcare team seemed to consider that his issues were, for the most part, related to his mental health while the mental health team thought his problems were mostly physical. He noted a lack of communication between the two teams, meant that the man's symptoms were not fully considered. We make the following recommendation:

**The Head of Healthcare should ensure that prisoners with complex needs reporting continuing severe pain have their symptoms thoroughly examined and investigated to determine their root cause and that all healthcare teams communicate effectively with each other.**

### Management of risk of suicide and self-harm

81. A mental health worker appropriately opened an ACCT on 11 August, when the man said he was feeling suicidal and hopeless. However, we are concerned that ACCT procedures were not well managed. In particular, we found that:

- There was no member of healthcare staff present at the first case review, which is contrary to the mandatory instruction in Prison Service Instruction 64/2011;
  - There was inconsistent case management (five chairs for eight reviews);
  - No member of the physical or mental health teams attended any ACCT review (although a substance misuse worker was at five of the reviews) although his risks were largely associated with his health;
  - Three of the reviews were not multi-disciplinary;
  - Several important events were not recorded on the ACCT;
  - The ACCT did not always travel with him around the prison;
  - The caremap was not used effectively to manage his immediate concerns;
  - There was no review of his risk after he harmed himself on 9 October or after his cellmate was moved on 10 October;
  - The level of observations was not always appropriate for the perceived level of risk of suicide and self-harm and not adjusted when his risk was regarded as high.
82. Several of the problems with ACCT procedures were caused by poor communication of risks. A nurse and an occupational therapist both reported not having the ACCT available when they saw the man for appointments. Important information, such as his cellmate, saying that he had not slept properly for 10 days because of him, or Prisoner A's comment to the officer about his level of risk on 11 October, was not recorded in the ACCT document and therefore other members of staff were unaware of it. None of the healthcare staff who saw him on 10 October recorded the consultation in the ACCT document. The officer did not record that the man's cellmate had been moved on 10 October, or her actions in trying to find a replacement. The caremap, which should set out the concerns that need to be addressed in order to support the prisoner and reduce his risk, did not mention his major issue for the last week of his life - his stomach pain, even though he had two ACCT case reviews in that time. There is no evidence the care map was updated from the time the ACCT was first opened. There was no healthcare representation at the ACCT reviews, which made it unlikely that this issue would have been addressed effectively.
83. We are also concerned that staff did not review the man's level of risk effectively. He was assessed as low risk of suicide and self-harm even after telling the member of the IAPT team on 4 September that he felt like hanging himself. On 8 October, he told a nurse that he wanted to die. Although she reported this to wing staff, no one reviewed his level of risk of suicide and self-harm, or consider whether he might need more frequent observations or other additional support. That night he cut himself, but again staff did not reassess his level of risk or increase the level of observations for some time after he returned from hospital. When staff reviewed his risk at a case review the next morning, they decided he was at high risk but did not raise the level of observations to reflect this. We are concerned that an officer and a SO had different accounts of this review and neither accepted that they had taken a record of the review.
84. The man's cellmate asked to move on 10 October and the man was left by himself in the cell. It is not clear who made this decision, as we have two different accounts of what happened and nothing was recorded in the ACCT document. However, this meant that he, who had been assessed as at high

risk of suicide and self-harm, was on his own in a cell. We consider that, before this was done, staff should have held a case review to assess whether they needed to find another cellmate immediately or take some other action to safeguard and support him, such as increasing the frequency of observations.

85. We do not know what prompted the man to take his life, or what interventions might have made a difference. He had been expressing suicidal thoughts before he began to report abdominal pain and was very anxious about his forthcoming release. However, ACCT procedures did not operate in line with national guidance and communication, recording of information and the assessment of his risk was poor. We make the following recommendation:

**The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidance, including:**

- **A multidisciplinary approach for all case reviews with continuity of case management;**
- **Healthcare staff attending all first case reviews;**
- **Setting ACCT caremap actions which are specific and meaningful, aimed at reducing prisoners' risks and reviewed and updated as necessary;**
- **All staff, including healthcare staff, recording relevant information about risk, observations and interactions with prisoners in ACCT documents and any action taken which might affect their risk.**

### **Emergency response**

86. Prison Service Instruction 3/2013 requires that governors must have a medical emergency response code protocol, which ensures that an ambulance is called automatically in a life-threatening medical emergency. Brixton has an appropriate emergency protocol. The PSI explicitly states that all prison staff must be made aware of and understand the protocol and their responsibilities during medical emergencies.
87. Officer A did not use a medical emergency code when he radioed the control room for help, but made it clear that he had found a prisoner hanging. While this does not appear to have delayed the initial emergency response, which was fast and effective, it meant that the nature of the emergency was not communicated well to all relevant staff. There was then a delay of three minutes before control room staff called an ambulance. It does not appear that the failure to use an emergency code or call an ambulance immediately, affected the outcome for the man, but in other emergencies this could be crucial. We make the following recommendation:

**The Governor should ensure that all prison staff are aware of and use the appropriate medical emergency response code in a life threatening situation and that the control room calls an ambulance immediately.**

## Staff support

88. PSI 08/2010 2010 – Post Incident Care - instructs that a hot debrief should be held in the immediate aftermath of a potentially traumatic incident, before staff immediately involved go home. However, the hot debrief was not held until 6.30pm on 11 October, by which time Officers A and B, the officers who had found the man hanged, had gone home. The PSI also requires prisons to hold a critical incident debrief within 5 –10 days. Part of the purpose is to ensure that staff have an opportunity to discuss the impact of what happened and to ensure that appropriate care and support is in place. No critical incident debrief was held after the man's death. Although staff said they were generally well supported, this debrief would have given them a further opportunity to review their feelings after his death, and would have been the only opportunity for both officers. We make the following recommendation:

**The Governor should ensure that after a death at the prison, staff are supported in line with PSI 08/2010**

## Investigation into allegations against the SO

89. On 15 October, the then Governor of Brixton informed us that a prisoner had made a complaint about a SO. He said that, on the morning of 11 October, the SO had ignored the man when he told her that he was in pain and that he had gone back to his cell and hanged himself. We advised the Governor that we would expect the prison to investigate the complaint, as they would normally do. We later received two letters from other prisoners making similar allegations, about which we informed the prison.
90. We interviewed the SO on 2 December. She said that she was aware of the allegations and said that they were untrue because she had spent almost all her time on B Wing that morning and had not seen the man that day. We have not seen any evidence to prove or disprove either her account or those of the prisoners and are unable to judge whether she spoke to him that morning. She told us that senior managers had asked her about the allegations, but that this had not, in her opinion, been handled appropriately. She had not been informed of the outcome.
91. On 21 January, our investigator asked an officer about the progress of the investigation. He replied that an internal investigation had been conducted and found that the allegations were unsubstantiated and no further action was to be taken. We have not seen a report of that investigation and it does not appear that a formal written report was completed.
92. Prison Service Order 1300 covers the investigations of incidents or allegations of misconduct. There are two possible types of investigation, simple and formal. The PSO states that a formal investigation should be completed either when there has been a major consequence, such as disorder or damage, or when there was serious harm to any person. We consider that the allegations against the SO met these criteria. PSO (paragraph 3B.1.3) states that there are two types of formal investigation, specialist (which includes matters relating to deaths in custody and misconduct which may require disciplinary action) and general. The circumstances of this allegation

include a direct reference to the man's death, and we consider that it should have been dealt with as a specialist investigation.

93. The PSO sets out, in detail, how the investigation should be conducted. In particular, it says that an interviewee should be given, and invited to sign, a written record of the interview and that a report should be completed. We have not seen any evidence that either of these mandatory requirements have been completed by Brixton, and are not satisfied that the investigation into such a serious allegation was properly conducted. We make the following recommendation:

**The Governor should ensure that there is an appropriate investigation into the allegations made by prisoners about the actions of the supervising officer on 11 October and that all serious allegations against members of staff are investigated in line with PSO 1300**

## RECOMMENDATIONS

1. The Head of Healthcare should ensure that prisoners with complex needs reporting continuing severe pain have their symptoms thoroughly examined and investigated to determine their root cause and that all healthcare teams communicate effectively with each other.
2. The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidance, including:
  - A multidisciplinary approach for all case reviews with continuity of case management;
  - Healthcare staff attending all first case reviews;
  - Setting ACCT caremap actions which are specific and meaningful, aimed at reducing prisoners' risks and reviewed and updated as necessary;
  - All staff, including healthcare staff, recording relevant information about risk, observations and interactions with prisoners in ACCT documents and any action taken which might affect their risk.
3. The Governor should ensure that all prison staff are aware of and use the appropriate medical emergency response code in a life threatening situation and that the control room calls an ambulance immediately.
4. The Governor should ensure that after a death at the prison, staff are supported in line with PSI 08/2010
5. The Governor should ensure that there is an appropriate investigation into the allegations made by prisoners about the actions of the supervising officer and that all serious allegations against members of staff are appropriately investigated, in line with PSO 1300.

**ACTION PLAN**

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that prisoners with complex needs reporting continuing severe pain have their symptoms thoroughly examined and investigated to determine their root cause and that all healthcare teams communicate effectively with each other.	Accepted	Every prisoner who complains of pain is given an appointment for the Tuesday Pain management clinic. The Chief Pharmacist and a GP attend each clinic where all complex cases are discussed. This information is then communicated to the wider healthcare team.	Completed	
2	The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in	Accepted	HMP Brixton aims to ensure that ACCT case reviews have a multi-disciplinary attendance, and where a team can't attend, a note is made to record contact made with them and any information shared. An ACCT cannot be assigned a single case manager due to shift		

	<p>line with national guidance, including:</p> <ul style="list-style-type: none"> <li>• A multidisciplinary approach for all case reviews with continuity of case management;</li> <li>• Healthcare staff attending all first case reviews;</li> <li>• Setting ACCT care map actions which are specific and meaningful, aimed at reducing prisoners' risks and reviewed and updated as necessary;</li> <li>• All staff, including healthcare staff, recording relevant information about risk, observations and interactions with prisoners in ACCT</li> </ul>		<p>patterns and staffing levels. Senior Officers are assigned this role as they are based on their wings for the majority of their working shifts which offers a good level of consistency.</p> <ul style="list-style-type: none"> <li>• A Staff Information Notice (SIN) was issued in April 2015 reminding staff of the requirement for multi-disciplinary attendance at ACCT case reviews. This requirement will be enforced through any further local ACCT training.</li> <li>• Healthcare staff will be invited to all first ACCT case reviews. The same SIN reminded staff that any newly opened ACCTs require healthcare attendance at the first case review. This will be monitored by regular management checks.</li> <li>• CAREMAP targets are set in all ACCT documents and these are reviewed at both ACCT case reviews, and before closing the documents. (A further check is carried out by the safer custody team before the closed ACCT is filed). To ensure that CAREMAP targets are specific to an individual's needs, the Safer Custody team will deliver Knowledge Based Skills to all Band 4's, and Band 5's will receive ACCT refresher training</li> <li>• All partner agencies and staff are asked to make ACCT entries. A SIN will be published reminding partner agencies to make ACCT entries. ACCT management checks will be</li> </ul>	<p>complete</p> <p>Safer Prisons &amp; Equality</p> <p>complete</p> <p>Safer Prisons &amp; Equality</p> <p>31/08/2015</p> <p>Safer Prisons &amp; Equality</p> <p>Complete</p>	
--	--	--	---	---	--

	documents and any action taken which might affect their risk.		undertaken by a Band 5 and Safer Custody Officer. In addition, the Head of Safer Prisons and Equality completes monthly ACCT checks reporting back at Safer Custody Meeting.	Safer Prisons & Equality	
3	The Governor should ensure that all prison staff are aware of and use the appropriate medical emergency response code in a life threatening situation and that the control room calls an ambulance immediately.	Accepted	<p>A SIN concerning emergency response was published on 25/09/2014, and following its issue this was discussed at staff briefings and by Custodial Managers with their teams. The Control Room has copies of the codes clearly displayed for reference. This SIN is to be republished and referred to at team briefings.</p> <p>This has also featured in the staff magazine 'Jebb'.</p>	<p>Complete</p> <p>Safer Prisons &amp; Equality, and Head of Residential Services</p>	
4	The Governor should ensure that after a death at the prison, staff are supported in line with PSI 08/2010	Accepted	<p>Local Hot and Cold debriefs were held following the man's death. However these were not conducted in line with PSI 64/2011 guidelines and therefore cannot be evidenced as such. A Critical Incident Debrief was not held.</p> <p>Functional heads have been given individual responsibility for each of the contingencies to ensure they are regularly tested and updated in line with current policy. This includes the need for immediate hot debriefs and critical debriefs where required</p>		

			<p>Following a death in custody:</p> <ul style="list-style-type: none"> <li>• Local contingency plans will be reviewed and updated.</li> <li>• Staff will be given a hand out on post trauma stress (available on the “My services” page on the NOMS/prison intranet)</li> <li>• The CARE team leader (or deputy) made aware of staff involved and make contact with them following a death in custody</li> </ul>	<p>Safer Prisons and Equality</p> <p>Head of Operations</p> <p>Care Team Leader / Deputy</p>	
5	<p>The Governor should ensure that there is an appropriate investigation into the allegations made by prisoners about the actions of the supervising officer on 11 October and that all serious allegations against members of staff are appropriately investigated, in line with PSO 1300.</p>	Accepted	<p>A manager was commissioned to carry out a simple investigation to ascertain the facts. The investigation was unfortunately not completed due to a change in the Senior Management Team. A new investigation will be commissioned to investigate the allegations made against staff.</p> <p>The Governor / Deputy Governor will ensure that Investigations are allocated to managers who will be responsible for ensuring that they are completed in line with specified timescales.</p>	<p>Governor / Deputy Governor</p> <p>30 June 2015</p> <p>Complete and ongoing</p>	