

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Daryl Brimfield, a prisoner at HMP High Down, on 29 August 2019

A report by the Prisons and Probation Ombudsman

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Daryl Brimfield was found hanged in his cell at HMP High Down on 29 August 2019. He was 27 years old. I offer my condolences to Mr Brimfield's family and friends.

Mr Brimfield had been at High Down for only a week when he was found hanged. I am concerned that prison and healthcare staff failed to consider all the documentation that arrived with him on 22 August, including a suicide and self-harm warning form, and they therefore failed to assess his risk properly. As a result, he was not managed under self-harm and suicide procedures (known as ACCT) which would have provided him with additional support.

Two days before Mr Brimfield died, an education worker saw that he had self-harmed by cutting his arms. She did not start ACCT procedures or tell prison or healthcare staff. This was a missed opportunity to put supportive measures in place.

Mr Brimfield never had a mental health assessment at High Down, despite a referral being made on 23 August, which should have been actioned within 72 hours.

Mr Brimfield was found hanged when his cell was unlocked shortly after 8.00am. There were signs he had been dead for some time. There was a delay in finding Mr Brimfield, as the early morning roll check that should have been carried out around 6.00am was not done, even though an officer signed to say she had done the check. Although the delay is unlikely to have affected the outcome because Mr Brimfield was probably dead at 6.00am, I am very concerned that an officer recorded that she had completed the roll check when she had not done so.

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

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Summary

Events

1. On 22 August 2019, Mr Daryl Brimfield was remanded in prison custody, charged with burglary and arson offences, and sent to HMP High Down. His Person Escort Record (PER) said he had considered an overdose the previous night. A suicide and self-harm warning (SASH) form completed by the police and an assessment by the Liaison and Diversion Mental Health Team also arrived with Mr Brimfield.
2. A nurse referred Mr Brimfield for a routine mental health assessment the next day, but the assessment was never done.
3. On 27 August, an education worker met Mr Brimfield and noticed that he had some small self-harm cuts on both of his arms. She asked him if he felt suicidal but he said he was okay and had no intention of harming himself. The education worker did not start suicide and self-harm prevention procedures (known as ACCT) or tell prison or healthcare staff about the cuts.
4. Shortly after 8.00am on 29 August, an officer unlocked Mr Brimfield's cell and found him hanging. There were signs that he had been dead for some time. Prison staff attempted to resuscitate him, but when ambulance paramedics arrived at 8.17am, they assessed that Mr Brimfield had died.

Findings

5. Mr Brimfield had several factors that increased his risk of suicide. He had allegedly committed offences against his ex-partner, had a history of mental health issues and previous suicide attempts, and had threatened to overdose the night before he entered High Down.
6. We found that Mr Brimfield's risk of suicide and self-harm was not properly assessed during reception. Staff failed to consider the information that arrived with him from the police and courts and relied only on Mr Brimfield's presentation.
7. Information relevant to Mr Brimfield's risk of suicide and self-harm was not considered during his basic custody screening.
8. As a result, ACCT procedures were not started and Mr Brimfield did not receive the additional support he needed.
9. We consider that the education worker should have started ACCT procedures when she realised that Mr Brimfield had self-harmed. This was a missed opportunity to put support measures in place for Mr Brimfield.
10. The clinical reviewer found the mental health care Mr Brimfield received was not equivalent to that he could have expected to receive in the community. A nurse referred Mr Brimfield for a routine mental health assessment the day after he arrived. This should have been completed within 72 hours, but was not done. The nurse did not read the information noted on Mr Brimfield's PER that he had considered an overdose while in police custody. There was also a delay in prescribing Mr Brimfield's antidepressant medication.

11. An officer signed to say she had completed a roll check at 6.00am on 29 August, but she had not done so. This meant that Mr Brimfield was not discovered until his cell was unlocked two hours later. Although it appears Mr Brimfield had been dead for some time when he was found, and that discovering him at the roll check is unlikely to have made a difference to the outcome, we are very concerned that an officer recorded that she had carried out the roll check when she had not done so.
12. Staff attempted to resuscitate Mr Brimfield when he was clearly dead, which is against resuscitation guidelines.
13. The number of prison staff on the wing during the emergency response hindered healthcare staff from attending the cell quickly with their emergency equipment.
14. Mr Brimfield had placed a strip of sheeting over his cell door, which he had used to hang himself from. An officer saw the sheeting hanging over the door when she locked him in his cell on the evening of 28 August. She said that many prisoners used a sheet in this way to hang their washing and she had no concerns. Prisoners are not allowed to attach items to their cell door. We consider that she should have challenged this and asked him to remove it.
15. We are also concerned that Mr Brimfield's cell was in a very poor state when he was placed there.

Recommendations

- The Governor should ensure that Officer A receives refresher training in ACCT and safer custody procedures as a matter of urgency.
- The Governor and Head of Healthcare should ensure that staff conducting reception assessments always examine and consider the Person Escort Record, and any other documents that arrive with the prisoner, to assess whether the prisoner has any risk factors for suicide and self-harm.
- The Governor should review the current arrangements for induction to ensure:
 - there are sufficient numbers of trained staff to complete the BCS1;
 - induction is managed more efficiently to reduce time taken locating prisoners;
 - assessors have easy access to computer systems; and
 - assessors adopt 'best practice' and consult prisoners' records.
- The Head of Healthcare should review:
 - review the training of clinical staff in depression identification;
 - introduce a brief checklist of questions and observations to exclude suicide risk; and
 - ensure that prisoners with mental health concerns are assessed within the required timeframe.

- The Head of Healthcare should ensure that there are sufficient prescribers available during evening reception and that there are no unnecessary delays in prescribing medications to new receptions.
- The Governor and Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is inappropriate in accordance with European Resuscitation Council Guidelines.
- The Governor should ensure that:
 - cell conditions are properly checked and documented;
 - repairs are promptly reported and fully documented and that there is a clear audit trail showing when the fault has been reported and when it has been resolved;
 - prisoners are not placed in cells that do not meet the minimum requirements, in accordance with PSI 17/2012; and
 - staff always challenge prisoners about items attached to a cell door and remove them.
- The Governor should share this report with Officers A and B and arrange for a senior manager to discuss the Ombudsman's findings with them.

The Investigation Process

16. The investigator issued notices to staff and prisoners at HMP High Down, informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
17. The investigator visited High Down on 2 September 2019, and obtained copies of relevant extracts from Mr Brimfield's prison and medical records and visited Houseblock 5 where she interviewed two prisoners. NHS England commissioned a clinical reviewer to review Mr Brimfield's clinical care at the prison.
18. The investigator interviewed twelve members of staff at High Down on 23 and 24 September. She also interviewed four members of staff by telephone.
19. We informed HM Coroner for Surrey of the investigation. The coroner gave us a copy of the post-mortem report. We have sent the coroner a copy of this report.
20. The Ombudsman's family liaison officer contacted Mr Brimfield's family to explain the investigation. Mr Brimfield's family wanted to know:
 - What was known about Mr Brimfield's mental health when he arrived at High Down.
 - Whether Mr Brimfield was assessed and received his medication.
 - Why he did not have telephone access.
 - Whether his location in the prison was appropriate.
 - Whether he received adequate access to showers, food and his own clothes.We have addressed these questions in this report.
21. Mr Brimfield's family received a copy of the initial report. They identified that the funeral date was incorrect, which has now been amended. They also raised several other points, which have been answered in separate correspondence.
22. The prison also received a copy of the report and did not identify any factual inaccuracies.

Background Information

HMP High Down

23. HMP High Down is a local prison in Surrey, which holds up to 1,150 men. Central and North-West London NHS Foundation Trust provides primary health services and in-reach mental health care. The healthcare unit has inpatient facilities with 24-hour nursing cover.

HM Inspectorate of Prisons

24. The most recent inspection of HMP High Down was in May 2018. Inspectors reported that standards had declined since the previous inspection, perhaps partly due to the uncertainty about the prison's future role and whether it was going to become a category C training prison.
25. Inspectors identified that there were insufficient spaces in the induction unit, because prisoners who had completed their induction had not been moved on. New prisoners were therefore located wherever there was space in the prison and were taken to poorly prepared, graffiti-covered cells, with no orientation or welcome from wing staff, sometimes late at night, and without a shower.
26. The next day, prisoners were taken to the resettlement centre, which operated a rolling two-day induction programme. Inspectors noted attendance at the induction programme had been unreliable for a long time due to staffing problems and regime restrictions, and induction completions had not been monitored. The prison had recognised the problem, and two dedicated staff had been assigned to oversee the process shortly before the inspection. The induction programme was found to be underdeveloped, comprising of a talk by peer workers in a noisy room in the resettlement centre.
27. Inspectors were concerned about the lack of purposeful activity with about 47% of prisoners locked in their cells during the working day. Inspectors found that support for those at risk of harm to themselves was variable and they found some examples of inadequate support for prisoners in crisis.

Independent Monitoring Board

28. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to December 2018, the IMB noted that induction took place regularly and new arrivals had support from peer advisors. The Board raised concerns about the number of working hours lost in the Offender Management Unit (OMU) because of staff being regularly cross-deployed, creating a backlog of work. They also expressed concern about the standard of ACCT procedures.

Previous deaths at HMP High Down

29. Mr Brimfield was the tenth prisoner to die at High Down in the past two years. Of these deaths, two were self-inflicted and seven were from natural causes.

Assessment, Care in Custody and Teamwork

30. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Managing prisoners at risk to self, to others and from others (Safer Custody)*.

Key Events

31. On 21 August 2019, Mr Daryl Brimfield was arrested for burglary and arson with intent to endanger life, and taken into police custody. Mr Brimfield told police that he had previously been sectioned under the Mental Health Act, but did not know when. He said he 'did not feel right in the head' and was very emotional asking for help. Hampshire Police referred Mr Brimfield to the Hampshire Liaison and Diversion Team (who identify people in contact with the criminal justice system who have mental health, learning disability or substance misuse vulnerabilities).
32. While in police custody, Mr Brimfield was assessed by the Liaison and Diversion Team, who noted that he had a history of low mood and suicide attempts (overdose and attempted hanging). Mr Brimfield also disclosed a history of misusing drugs and alcohol. Mr Brimfield said he had been prescribed antidepressants a month earlier and, although he had abstained from alcohol, he had recently started drinking heavily. The Liaison and Diversion Team noted that Mr Brimfield wanted to access support and that they would refer him to the Community Mental Health Team (CMHT) for assessment by a psychiatrist. They advised that due to Mr Brimfield's high level of anxiety, an appropriate adult should be used when he was interviewed. Mr Brimfield was checked regularly while he was in police custody.
33. On 22 August, Hampshire Police completed a Suicide and Self-Harm (SASH) Warning Alert which said that Mr Brimfield had considered an overdose the previous night. Mr Brimfield appeared at court, was seen again by the Liaison and Diversion Team, and was remanded in prison custody. This was not his first time in prison.
34. Mr Brimfield arrived at HMP High Down around 4.15pm. On his Person Escort Record (PER - a document that accompanies all prisoners when they move between police stations, courts and prisons and which sets out the risks they pose), court staff had recorded that Mr Brimfield said that he struggled to process things said to him. In the risk section they noted under suicide and self-harm, 'Took overdose three years ago, considered taking overdose last night (21/8/19)'. The assessment by the Liaison and Diversion Team and the SASH form completed by Hampshire Police also arrived at High Down with Mr Brimfield.
35. At 5.41pm, an officer recorded on Mr Brimfield's prison record that he had been admitted to High Down. Officer A completed Mr Brimfield's cell sharing risk assessment (CSRA) and noted, 'Arsonist – High Risk Block PIN vape kit + 2x caps'. A nurse noted there were no healthcare issues that increased his risk and the Head of Security authorised the assessment which meant Mr Brimfield would be in a single cell.
36. Officer A completed the First Night in Prison interview (FNIP) and recorded that she had checked all relevant documents. She incorrectly recorded that there was no self-harm warning; no other risk factors were identified. In the self-harm history section of the reception assessment, she recorded that Mr Brimfield had taken an overdose 'years ago' but currently had no suicidal thoughts. There is no reference to the risk warning information that arrived with Mr Brimfield. She did not make an entry on Mr Brimfield's prison record.

37. At 7.09pm, an officer recorded that Mr Brimfield had completed his first night interview. He noted that Mr Brimfield was high risk for cell-sharing and had signed all of the relevant reception documents. He noted that Mr Brimfield's PIN phone had been issued (the PIN was issued but Mr Brimfield had to wait for his telephone numbers to be authorised by security). He also noted that Mr Brimfield had no thoughts of suicide or self-harm and advised him how to access the Samaritans or Listeners (prisoners trained by the Samaritans to support other prisoners), which he declined.
38. At 7.59pm, a nurse recorded in Mr Brimfield's medical record that she had completed his initial health screen. She incorrectly noted that he had never been to prison before. She noted Mr Brimfield said he occasionally binged on alcohol and was prescribed an antidepressant (sertraline) which had recently been increased to 100mg. She recorded that Mr Brimfield had had no contact with mental health services, had never been sectioned and had no current thoughts of suicide or self-harm. She referred Mr Brimfield to the prison doctor. (During the consultation period, Mr Brimfield's mother responded and said a female prison officer contacted her and confirmed that she was happy to take a call from Mr Brimfield. Mr Brimfield's mother said she spoke to her son for 8 minutes and 40 seconds at 8.10pm, but there was no evidence of this call provided by the prison). At 8.27pm, Mr Brimfield was moved to Houseblock 5 as there were no single cells available in the induction unit.
39. On 23 August, Mr Brimfield attended the resettlement unit for his induction talk. There is no time recorded on the log, but an Operational Support Grade (OSG) noted, '[Mr Brimfield] discreetly asked for mental health. I could see he was trying to hide his distress. Moved him to the kitchen where he got upset & explained he has anxiety. Informed the officer & one of the orderlies [another prisoner] went in to chat to him'. She told the investigator that she did not have any concerns that Mr Brimfield felt like harming himself, but believed he was just overwhelmed. After he had spoken to the prison orderly, he said he felt okay and she did not think it was necessary to start ACCT procedures. An officer told the investigator that he was working in the resettlement unit, but was not told that Mr Brimfield had been upset.
40. Later that day, a prison GP recorded in Mr Brimfield's medical record that he had mixed anxiety disorder, but did not see him. The GP noted Mr Brimfield had recently had his antidepressant medication increased from 50mg to 100mg and prescribed this medication. At 2.14pm, a nurse received information from the Liaison and Diversion Team, which said they had assessed Mr Brimfield while in police custody and at court, that he struggled with his emotions and had had thoughts of suicide, but said he would not act on these. She referred Mr Brimfield to the mental health team for a routine assessment. (This should have been completed within 72 hours but was not done before Mr Brimfield died.)
41. That afternoon, an offender supervisor recorded that he had completed Mr Brimfield's basic custody screening. He completed information relating to Mr Brimfield's accommodation, employment, finances, relationships, and health and well-being. He noted Mr Brimfield had been in contact with mental health services and wanted support with managing his temper and being impulsive. He referred Mr Brimfield to the mental health team.

42. Also, that afternoon, a prison chaplain recorded in Mr Brimfield's prison record that she had completed an induction visit. She recorded that Mr Brimfield was distressed and that they had prayed together. She recorded that she had telephoned Mr Brimfield's mother to tell her that he was at High Down.
43. That evening, wing staff contacted healthcare staff as Mr Brimfield had not been issued with his antidepressant medication. A nurse recorded that Mr Brimfield would be issued with his medication, which should be taken in the morning, from the next day.
44. On 24 August Mr Brimfield had a visit from his mother, but there are no other details recorded. In the afternoon, Mr Brimfield used the wing kiosk to submit his mother's and step-father's telephone numbers for security clearance to enable him to use the PIN phone. Because Mr Brimfield had a restraining order preventing him from contacting certain individuals, these telephone numbers had to be security cleared.
45. At 9.02am on 24 August, and the next day at 9.10am, a nurse recorded in Mr Brimfield's medical record that his antidepressant medication had been administered. She also recorded, 'Depression Questionnaire: No action required'. On 26 August, at 9.03am, another nurse made a similar entry on the medical record. There is nothing to explain why these nurses considered no action was necessary.
46. All prisoners' telephone calls, except those that are legally privileged, are recorded, and prison staff listen to a random sample. Mr Brimfield did not make any telephone calls using the PIN system while he was at High Down. However, an officer told the investigator that over the Bank Holiday weekend (24 & 25 August) Mr Brimfield said he had a problem with his PIN and asked him to contact his father. He said he checked Mr Brimfield's prison records and noted that he was subject to a restraining order, but that this order related to two females, so he contacted Mr Brimfield's father. He obtained Mr Brimfield's father's contact details for him and said that his father intended to visit him and send him some money. He said Mr Brimfield appreciated his help.
47. On the morning of 27 August, a nurse noted in Mr Brimfield's medical record that he was not taking his medication as prescribed and completed a depression questions assessment. The nurse referred Mr Brimfield to the prison doctor.
48. An induction tutor in the education department completed a learning support plan with Mr Brimfield. She noted that he told her he suffered from depression and was struggling with his current domestic situation and missed his family. Mr Brimfield told her that he had been prescribed antidepressant medication about six weeks earlier, but he felt it was having a negative effect on him. She recorded that Mr Brimfield would benefit from reassurance, support, contact with the healthcare team and starting education classes to keep him busy. She referred Mr Brimfield to the learning support coordinator. She said that throughout the induction Mr Brimfield gave her no cause for concern.
49. The learning support coordinator met with Mr Brimfield soon after his induction at around 10.45am. She said she spent around 45 minutes with Mr Brimfield and that initially he spoke about sorting out vape capsules and contact with his family.

However, he became tearful and said he was frustrated at trying to get help with his mental health and that he suffered from anxiety and depression and with support he might not have committed his offences. Mr Brimfield spoke about his distress that he might not be allowed to see his partner and their unborn child. Mr Brimfield said that he had been prescribed an antidepressant, but that it was making him feel worse.

50. Although she did not record it in the assessment, the learning support coordinator told the investigator that she noticed Mr Brimfield had some small self-harm cuts on both his arms and asked if he was being supported by Prison Service suicide and self-harm prevention measures (known as ACCT). She said that she told Mr Brimfield what ACCT procedures were and she asked him several times if he felt suicidal, but he reassured her that he was okay and did not intend harming himself. She said she gave Mr Brimfield information about the Listeners and Samaritans, and he said he would make an appointment to speak with the prison doctor. There are no entries on either Mr Brimfield's prison or medical records about these education assessments and she did not contact anyone on Houseblock 5 to flag her concerns about Mr Brimfield self-harming.
51. At 11.30am, a pharmacy technician completed an in-possession medications review and deemed Mr Brimfield suitable to hold his medication in possession (that is, keep it in his cell, instead of having to collect it and take it under the supervision of nurses), although his medication was not changed to in-possession at the time. He noted that Mr Brimfield said that he did not have any problems with drugs or alcohol, that he had no history of suicide attempts or self-harm within the past year and there had been no recent life-changing event.
52. On the afternoon of 28 August, a senior physical education instructor recorded that Mr Brimfield had completed his gym induction. However, this induction was completed by his colleague, who told the investigator that there was nothing about Mr Brimfield's demeanour that caused any concern. This is the last entry on his prison record. The officer recalled seeing Mr Brimfield on the wing after his gym induction, but said that he did not come to his attention and there was nothing about his behaviour that raised any concerns.
53. Mr Brimfield was locked in his cell by an officer at around 5.30pm. She told the investigator that another prisoner made a comment about a piece of green bed linen that was protruding from the top of Mr Brimfield's cell door. She asked Mr Brimfield if he was okay and he said he was. She said that many prisoners use bed sheets to hang their washing or protect their privacy while using the toilet and that there was no indication that anything was wrong. She said she knew Mr Brimfield was not on an ACCT and therefore did not have any concerns about him.

Thursday 29 August

54. Officer B signed to say that she had completed the early morning roll check at 6.00am, but CCTV shows this did not happen. At around 8.00am, Officer C started to unlock cells on Mr Brimfield's landing. CCTV shows him looked through the observation panel of Mr Brimfield's cell, where he saw him with a ligature around his neck. He immediately shouted for assistance while opening the door. Officer D saw Officer C struggling to open the cell door, and thought

there was a barricade or struggle with a prisoner so raised a general alarm. Officer D went to the cell with other officers, including a Supervising Officer (SO), who radioed an emergency code blue at 8.01am (used to indicate a prisoner is unconscious or having breathing difficulties).

55. Officer C said that when he entered the cell, Mr Brimfield was cold and stiff and that his body was in an unusual position. He used his anti-ligature knife to remove the ligature. He said he could see no signs of life, could not feel a pulse and was certain that Mr Brimfield was already dead. Because a general alarm had initially been raised, numerous prison staff entered the wing.
56. Two nurses, who were already on the houseblock, responded to the emergency code and they arrived at Mr Brimfield's cell less than a minute later. Mr Brimfield was taken out of the cell onto the landing as there was more space, and the SO started cardiopulmonary resuscitation (CPR). The automatic defibrillator indicated that Mr Brimfield had no shockable rhythm, but staff continued CPR until paramedics arrived about 15 minutes later. All staff who responded to the emergency described Mr Brimfield as cold, grey in colour and that his body was stiff. A nurse recorded that Mr Brimfield's jaw was clamped, his tongue swollen and that his neck was bruised. Mr Brimfield was cold to touch and his blood had started to pool: all signs that someone has been dead for some time.
57. South East Coast Ambulance Service records show they received a request for an ambulance at 8.02am. When paramedics arrived on Houseblock 5 at 8.17am, they examined Mr Brimfield and declared that he had died. Paramedics noted there were 'obvious signs of post-mortem lividity' (when blood pools due to a lack of circulation). Paramedics noted that they had been advised on their way to the prison that Mr Brimfield was dead. (There is a record at 8.05am in the prison occurrence log that the ambulance crew was informed Mr Brimfield had died.)
58. Several letters were found in Mr Brimfield's cell, dated between 23 and 29 August, addressed to his ex-partner, parents and friends. Mr Brimfield wrote that he was 'a broken man' and repeatedly apologised for the hurt he had caused and that he had let everyone down. In one letter dated 25 August to his father, Mr Brimfield wrote that he was very lonely, was waiting for his phone numbers to be added to his PIN and was seeking help in prison. Mr Brimfield wrote that he had lost weight as he had not been eating, and was living in a 'sweat box'. In another letter, he wrote that at times he had been locked in his cell for 21½ hours each day. Mr Brimfield also wrote about not knowing when he was going to get out of prison and that, unlike when he had served a previous sentence and knew for definite when he would be released, he was 'going crazy with boredom'.
59. Mr Brimfield had also posted letters which were intercepted in the internal post after his death. In one letter he wrote that he had only seen someone from the mental health team on the night he arrived and that he thought they were meant to help him. In a letter to his partner, Mr Brimfield wrote that he had started to cut himself to take away his pain at being away from his family. Mr Brimfield left specific details for his funeral.
60. Officer C told the investigator that after Mr Brimfield's death, a prisoner who was a Listener, said that Mr Brimfield had had a cut on his arm during exercise the previous day. This prisoner told him that he did not tell prison staff because Mr

Brimfield had reassured him that he was already on an ACCT and so he did not need to take it any further.

61. Another prisoner said he had only seen Mr Brimfield a couple of times on the wing. He said he spoke to Mr Brimfield the day before he died, as he saw a piece of material on the top of the cell door so he looked in. The prisoner said Mr Brimfield was smiling, doing some washing in the sink and appeared happy. He said he had no concerns about Mr Brimfield and that it was not unusual to see prisoners using bits of material to hang their washing up as there was only one working washing machine on Houseblock 5 for around 80 prisoners. The prisoner said he saw no visible self-harm marks on Mr Brimfield's arms and described him as personable and friendly. He said that after Mr Brimfield's death, other prisoners said they had no idea he was struggling and that he always seemed happy and friendly.

Contact with Mr Brimfield's family

62. The prison appointed a Custodial Manager (CM) as the family liaison officer (FLO) and a SO as her deputy. The Governor accompanied the FLOs and they travelled to Mr Brimfield's mother's address, his nominated next of kin. However, there was no answer. The FLO telephoned her to tell her the news of her son's death. Mr Brimfield's mother explained that she was on holiday, but would return later the same day.
63. The FLOs met with Mr Brimfield's mother the same day at her home to provide more information. Mr Brimfield's father's contact details were provided to the FLO and she telephoned him at 4.18pm to inform him of his son's death. The prison provided ongoing support and contributed towards the costs of Mr Brimfield's funeral, which was held on 20 September, in line with national policy.

Support for prisoners and staff

64. The duty governor held a hot debrief with all staff involved. Staff said they felt well supported and the Post-Incident Care Team spoke to everyone involved. Staff were told that they could go home if they wanted to and the chaplaincy and mental health team offered to provide support to anyone affected by Mr Brimfield's death. A critical debrief was arranged for 16 September, facilitated by an external service. Although the Head of Healthcare had been made aware of the meeting, healthcare staff were not informed and therefore did not attend.
65. The prison posted notices informing other prisoners of Mr Brimfield's death, and offering support. Staff reviewed all prisoners considered to be at risk of suicide and self-harm, in case they had been adversely affected by Mr Brimfield's death.

Post-mortem report

66. The post-mortem report concluded that Mr Brimfield died from hanging. Toxicology results showed that Mr Brimfield had not taken any drugs, other than those prescribed.

Findings

Assessment and management of Mr Brimfield's risk of suicide and self-harm

67. We are concerned that Mr Brimfield's risk of suicide and self-harm was not adequately assessed for the reasons set out below. If he had been properly assessed, we think that he would have been managed under ACCT procedures. This would have provided him with more support, although we cannot know whether that would have made a difference and prevented Mr Brimfield's death.

Reception procedures

68. We are concerned that when Mr Brimfield arrived at High Down on 22 August 2019, reception staff failed to consider the information that arrived with him and therefore failed to assess his risk of suicide and self-harm properly.
69. Prison Service Instruction (PSI) 07/2015, *Early Days in Custody*, says that all prisoners should be risk assessed for potential harm to themselves, to others and from others and that prisoners assessed as at risk of suicide and self-harm should have support identified and managed. It says that the PER and any other available documentation must be examined in reception to assess the risk of self-harm or harm to others by the prisoner, or harm from others. It also says that all newly arrived prisoners must be assessed as part of the reception health screen process to assess whether they are at risk of suicide or self-harm.
70. A nurse told the investigator that she did not look at Mr Brimfield's PER, which contained relevant information about his mental health and recent alcohol use and was not aware of the assessment completed by the Liaison and Diversion Team.
71. Officer A said she did not recall Mr Brimfield. She told the investigator that she often did not have sight of documents that arrived with a prisoner when completing FNIP assessments, as the Supervising Officer (SO) would identify any issues and risks and officers would rely on the information the SO gave them. She described the process as 'hit and miss'. She accepted that she had incorrectly recorded that she had viewed all available documents and said it was recorded 'automatically'. She said she had not received any specific training for undertaking her duties in reception and had not received any ACCT training, other than during her initial prison officer training.
72. Another officer told the investigator that although he recorded information on Mr Brimfield's prison record, this was given to him by Officer A. He said he was shocked when informed that Mr Brimfield had arrived with information about his risk of suicide and self-harm and said that he had never seen the documents.
73. We are concerned that Officer A felt that she was not sufficiently familiar with ACCT procedures. PSI 07/2015 says that staff dealing with prisoners in reception must be aware of, and comply with, national and local instructions on preventing suicide and managing self-harm. PSI 64/2011 says that all staff in contact with prisoners must be trained in ACCT procedures and that from January 2012 all new staff must be trained in Introduction to Safer Custody. It

also says that ACCT refresher training must be provided according to local training needs. We recommend:

The Governor should ensure that Officer A receives refresher training in ACCT and safer custody procedures as a matter of urgency.

74. The PER and other documents that arrive with a prisoner contain information that is crucial to assessing his risk to himself or others. Nurses and officers who see prisoners in reception must see and read this information. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff conducting reception assessments always examine and consider the Person Escort Record, and any other documents that arrive with the prisoner, to assess whether the prisoner has any risk factors for suicide and self-harm.

Induction (Basic Custody Screening)

75. *OASys Guidance – Basic Custody Screening Manual*, dated December 2014, sets out the expectations for identifying the needs of new prisoners. It is not designed as an assessment of risk. The BCS is a two-part screening tool: the BCS1 is completed by an offender supervisor (OS) within three calendar days and covers needs (e.g. accommodation, finances); and the BCS2 assessment is completed by a resettlement officer within five working days.
76. The BCS Manual states: *'It is important that the OS interviews the prisoner prior to completing the BCS. If time allows it would be seen as 'best practice' for the OS to view the Pre-Sentence Report and any other relevant information before completing the BCS, however pre-reading is not a requirement for the completion of the BCS.'* The day after Mr Brimfield arrived he completed his induction and met with his offender supervisor, who completed his BCS1. The offender supervisor correctly referred Mr Brimfield to the mental health team. He did not complete the risk screening section of the BCS as there is no requirement to do so.
77. Although there is no expectation that previous OASys assessments (an assessment of risks and needs) are accessed prior to the completion of the BCS1, the investigator identified that Mr Brimfield's OASys assessment dated 5 December 2018, contained information which outlined that his risk to himself increased when his relationships broke down. As Mr Brimfield was on remand for alleged offences committed against his ex-partner, this information was very relevant.
78. The investigator spoke to several Prisoner Offender Managers (POMs) from the Offender Management Unit (OMU) who completed BCS1s. They expressed frustration that the induction process could be disjointed, that they often did not have easy access to computers to check historical and current information and that frequently prisoners did not arrive for induction which meant they spent time chasing individuals.
79. The manager of the OMU at the time Mr Brimfield was at High Down said that previous prison records and OASys assessments would only be viewed if there were concerns about a prisoner. She said the availability of staff in OMU was

also a factor, as they were often cross-deployed to other tasks and did not have time. The problems of staffing induction were also identified during the most recent HMIP inspection.

80. While there is no current requirement to complete the risk section during the BCS1, or routinely review previous OASys assessments, we consider that potential signs of increased risk of suicide and self-harm would be easier to identify if an assessor had some knowledge about a prisoner's history. We therefore make the following recommendation:

The Governor should review the current arrangements for induction to ensure:

- **there are sufficient numbers of trained staff to complete the BCS1;**
- **induction is managed more efficiently to reduce time taken locating prisoners;**
- **assessors have easy access to computer systems; and**
- **assessors adopt 'best practice' and consult prisoners' records.**

Response to Mr Brimfield's self-harm

81. PSI 64/2011, *Managing prisoners at risk of harm to self, to others and from others (Safer Custody)*, lists several risk factors and potential triggers for suicide and self-harm and sets out the process for starting Prison Service prevention measures (known as ACCT).
82. On 27 August, the learning support coordinator noticed that Mr Brimfield had four to five cuts on his arms and described these as 'deeper than scratches'; some were a couple of days old, some older. She did not start ACCT procedures as Mr Brimfield assured her that he did not feel suicidal. Although she noted on Mr Brimfield's education plan that he needed support and reassurance, she did not tell wing or healthcare staff of her concerns. PSI 64/2011 is clear that ACCT procedures should be started after any incident of self-harm.
83. Suicide and self-harm prevention measures should have been started by the learning support coordinator, who had been trained in ACCT procedures and was aware of the requirement. She was unable to explain why she did not start ACCT procedures, other than she had been sufficiently reassured by Mr Brimfield, but reflected that she should have not relied solely on his presentation. This was a significant oversight and a missed opportunity in providing Mr Brimfield with support. We would have recommended the Governor conduct a disciplinary investigation, but she no longer works at High Down.

Access to PIN phone, shower facilities and food

84. Mr Brimfield's family said contact with them would have been a protective factor and were concerned that he had not been able to make any telephone calls while at High Down. PSI 49/2011 – *Prisoner Communication Services*, sets out the requirements for all prisoner communication, including telephone use. The PSI says, '*The checking of social numbers must be proportionate to risk and checked as necessary in accordance with the NSF [National Security Framework] and as set out in the local security strategy*'.

85. Mr Brimfield was subject to a Restraining Order and, therefore, for security reasons, his numbers had to be verified before he could use his PIN. He submitted his telephone numbers for checking on Saturday 24 August, and Officer C made a telephone call to Mr Brimfield's father on his behalf. High Down's local policy states any requests to have telephone numbers added to the PIN phone should be completed within five working days. This meant, because it was a Bank Holiday weekend, High Down had until 2 September, to verify and authorise these numbers. This was not completed before Mr Brimfield died. We are satisfied that, in the circumstances, there was no undue delay in authorising the PIN numbers.
86. It was good practice for Officer C to make a telephone call on Mr Brimfield's behalf.
87. We found no evidence that Mr Brimfield was not able to access the showers located on Houseblock 5 or had any issues with his food.

Clinical care

88. The clinical reviewer concluded that overall Mr Brimfield's clinical care was not of the standard he could have expected to receive in the community.

Mental health management

89. On 23 August, a nurse received information that Mr Brimfield had been assessed by the court Liaison and Diversion Team while in police and court custody. She was unaware of the information contained in the PER which said Mr Brimfield had recent suicidal thoughts. She made a routine referral for Mr Brimfield to be assessed by the mental health team, which she believed meant that he would be assessed within 7-10 days of the referral. Given the information contained in the PER, we do not consider this was prompt enough.
90. Although the nurse thought that she was referring Mr Brimfield for an assessment within 7-10 days, in fact High Down's mental health inreach team's referral process states that someone referred as 'routine' would be seen within 72 hours. Mr Brimfield should, therefore, have been assessed by 25 August, but this did not happen. We therefore make the following recommendation:

The Head of Healthcare should:

- **review the training of clinical staff in depression identification;**
- **introduce a brief checklist of questions and observations to exclude suicide risk; and**
- **ensure that prisoners with mental health concerns are assessed within the required timeframe.**

Prescribed medication

91. PSO 3050 – *Continuity of healthcare*, says all prisoners who arrive in prison custody should have an initial healthscreen while in reception, and if appropriate,

be referred to the doctor to assess their physical and mental health needs, including any medication they may be prescribed.

92. Mr Brimfield was prescribed antidepressant medication, which was continued when he arrived in prison. A prison GP prescribed this medication on 24 August, as there was no doctor available in reception when Mr Brimfield arrived on 22 August. Prison healthcare have not explained why the medication was not prescribed on 23 August. Although the short delay in prescribing Mr Brimfield's medication would not have had a detrimental effect, Mr Brimfield was clearly concerned about it and this may have impacted on his level of stress and anxiety. We therefore make the following recommendation:

The Head of Healthcare should ensure that there are sufficient prescribers available during evening reception and that there are no unnecessary delays in prescribing medications to new receptions.

Early morning roll check

93. Officer B signed to say that she had completed a roll check on the morning of 29 August when she had not done so. The officer completed her officer training in April 2019, and this was her first set of night shifts. She told the investigator that she had been told by a more experienced officer that if there had been no movement on or off the houseblock, she did not need to physically go around and check every cell. We do not know when Mr Brimfield took his own life and do not know if he would have been discovered sooner.
94. In response to the missed roll check, the Governor investigated why the roll check had not been properly completed. She issued a Governor's Information Notice (GIN) 67/2019 dated 30 August, reminding all night staff about the expectations of completing their duties. The GIN reiterates that a full count and welfare check should be completed, regardless of whether there has been any movement on the wing. The GIN also states that if prisoners cannot be seen in their cells, night staff should try and obtain a response and if they are unable to do so they should call for further assistance. Given the Governor's notice, we do not make a separate recommendation.

Emergency Response

Resuscitation

95. In September 2016, Professor Sir Bruce Keogh, National Medical Director at NHS England, wrote to Heads of Healthcare for prisons introducing new guidance to support staff on when not to perform cardiopulmonary resuscitation. This guidance was designed to address the issue of inappropriate resuscitation following a sudden death in a prison and was taken from the European Resuscitation Council Guidelines 2015 which state, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile".
96. Officer C, who discovered Mr Brimfield, said he was clearly dead. Paramedics recorded there were obvious signs of death when they assessed Mr Brimfield:

there was no circulation, he was cold to the touch and signs of blood pooling were present, all indicators that he had been dead for some time.

97. In interview, not all prison staff were aware of the guidance on when not to perform CPR. The nurses that responded said they believed Mr Brimfield was dead, but that they wanted to give Mr Brimfield every opportunity for survival and waited for a second opinion from the visiting paramedics.
98. We understand the commendable wish to attempt and continue resuscitation until death has been formally recognised, but staff should understand that they are not required to carry out CPR in these circumstances. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased. We therefore make the following recommendation:

The Governor and Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is inappropriate in accordance with European Resuscitation Council Guidelines.

Management of incident

99. CCTV footage shows that numerous prison staff responded to the initial general alarm. Those prisoners that had already been unlocked were quickly locked back into their cells, blankets were used as a make-shift screen to prevent prisoners in opposite and neighbouring cells observing the emergency response and all observation panels were closed. However, many prison staff remained on the wing, congregating around Mr Brimfield's cell. Prison staff unintentionally obstructed healthcare staff who had responded to the emergency code from gaining easy access and they had to walk the long way around the landing to Mr Brimfield's cell. Someone should have taken responsibility for managing the incident when it became clear it was not a general alarm.
100. Mr Brimfield was moved onto the landing area, where there was more room, to make it easier for staff to administer CPR. After paramedics had declared that he was dead, Mr Brimfield's body was covered with a blanket. All staff left the wing, and one officer returned who sat on the opposite side of the landing. However, Mr Brimfield's body was left lying on the landing for nearly 11 minutes.
101. The duty governor accepted that it was unfortunate that Mr Brimfield had not been moved back into his cell more quickly. However, he said that staff who had been involved in the resuscitation attempt had been traumatised and had to be escorted off the houseblock. He said that he was conscious that he did not want to traumatise any further staff and the delay returning Mr Brimfield's body into his cell was due to him finding staff with sufficient emotional resilience.
102. A prison manager said that while the duty governor was identifying staff to move Mr Brimfield's body back into his cell, she and her colleagues were taking advice from paramedics about the most dignified and safe way to move him. The duty governor contacted the prison chaplain so they could be present when Mr Brimfield was moved.
103. We are satisfied that Mr Brimfield's body was treated with respect.

Cell condition

104. PSI 17/2012 - *Certified Prisoner Accommodation*, sets out the minimum requirements for a cell to be occupied by prisoners. Mr Brimfield's cell on Houseblock 5 was in a very poor state. A large section of the wall and part of the ceiling were covered in dark coloured pages from comic books, which had been pasted onto the cell by the previous occupant. It appeared that there had been an attempt to remove them from the walls, which left ripped and torn paper on the walls. (We do not know if Mr Brimfield had done this.) On the opposite wall above the sink, the walls were covered in dried toothpaste, commonly used by prisoners to stick posters or photos to the walls.
105. We found it difficult to establish how this cell had been allowed to remain in the state it was when Mr Brimfield was placed there. Another prisoner who worked as a painter on the houseblock told the investigator that Mr Brimfield had asked him to repaint his cell. He said he felt bad that he had not been able to assist Mr Brimfield before he died. A CM said that daily fabric checks are carried out on 25% of cells, to check that they comply with the standards expected. He said that he had confirmed these checks had been completed, but there is no record of any concerns noted about Mr Brimfield's cell, or if it was one of the cells that had been checked.
106. Regardless of how or when the damage occurred, it is clear that the walls and ceiling were not in an acceptable state from the time that Mr Brimfield went into the cell on 22 August. We consider that the condition of the cell was unacceptable and not in accordance with PSI 17/2012. We do not consider that any prisoner should have been placed in a cell like this. We consider that the cell conditions may have had a negative impact on Mr Brimfield's mental health and that he should never have been placed in such an environment.
107. Mr Brimfield had placed a strip of sheeting over the top of his door and used this as the anchor for his ligature. An officer saw the sheeting when she locked Mr Brimfield's door the night before he died. She spoke to Mr Brimfield, she had no concerns and assumed that he, like many prisoners, was using the sheet to create a line to dry his washing on. She said she was not certain if this practice was allowed, but said it was commonplace.
108. A CM said prisoners should always be challenged and that nothing should be attached to the cell door, but that there had been a recent problem with the laundry facilities and using a line in cells had become common practice. We make the following recommendation:

The Governor should ensure that:

- **cell conditions are properly checked and documented;**
- **repairs are promptly reported and fully documented and that there is a clear audit trail showing when the fault has been reported and when it has been resolved;**
- **prisoners are not placed in cells that do not meet the minimum requirements, in accordance with PSI 17/2012; and**
- **staff always challenge prisoners about items attached to a cell door and remove them.**

Learning from this report

109. We consider it important that staff should learn the lessons from this report. We therefore recommend:

The Governor should share this report with Officers A and B and arrange for a senior manager to discuss the Ombudsman's findings with them.

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