PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

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

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 the man, who was found hanging in his cell at HMP Brixton in February 2014. He was 60 years old. I offer my condolences to his family and friends.

A review of the clinical care the man received in custody was undertaken. The prison cooperated fully with the investigation.

The man was sentenced to five years in prison on 27 January 2014 and initially went to HMP Pentonville for just over a week. He transferred to HMP Brixton on 6 February. There is little indication that he received an appropriate induction to prison life at Pentonville and he had not yet begun an induction at Brixton. No one at either prison identified him as at risk of suicide or self-harm and he gave no indication that he intended to harm himself.

One morning in February, an officer found the man hanging in his cell. He went in immediately and, assisted by other staff, attempted to resuscitate him. An officer called an emergency medical code but the control room did not call an ambulance automatically as should have happened. A prison doctor arrived at the cell shortly after the emergency was called and, after examining him, pronounced him dead.

I am satisfied that prison staff appropriately assessed the man's risk and that it would have been difficult to foresee or prevent his death. However, there is a need to improve induction arrangements for new arrivals at both prisons. He received a satisfactory standard of healthcare during his short time at Brixton which was equivalent to that which he could have expected in the community. Although it would not have changed the outcome in his case, there is a need for Brixton to ensure that all staff follow the required emergency procedures and call an ambulance as soon as there is a medical emergency.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **November 2014**

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SUMMARY

1. On 27 January 2014, the man was convicted of sexual offences and sentenced to 5 years imprisonment and was taken to HMP Pentonville to begin his sentence later that evening.

2. At Pentonville, a nurse at an initial health screen assessed the man as a low risk of suicide and self-harm. He spent his first night in prison in a single cell in the prison's induction unit as staff did no identify him as a vulnerable prisoner who needed to be kept apart from the general population because of his offence.

3. On the morning of 28 January, a nurse assessed the man at a second health screen and had no concerns about him. An officer recorded that he had attended an induction session that morning and his name appeared on a cell sharing risk assessment. The officer says he did not complete the assessment and we are also concerned that someone appears to have entered the name of a doctor who did not work at Pentonville on the assessment. He moved to a cell in the vulnerable prisoner's unit later that morning. Pentonville staff recorded little contact with him after this.

4. On 6 February, the man transferred to HMP Brixton, a resettlement prison. When he arrived at Brixton, prison and healthcare staff did not identify any concerns and he moved to a single cell in the vulnerable prisoners unit.

5. Over the following days, the man had little direct contact with prison staff, but those who saw him had no concerns about him and did not consider he appeared at risk of suicide or self-harm. Prisoners who spoke to him on the wing said he generally appeared quiet but not depressed, and gave no indication of the action he was going to take. After he died, one prisoner said that he believed that other prisoners had bullied him, but we found no evidence of this.

6. One morning in February, an officer found the man hanging while he was unlocking his cell. He went into the cell immediately and, helped by other staff, tried to resuscitate him. An emergency code was called but the control room did not call an ambulance immediately. A prison doctor attended and pronounced that he had died.

7. The investigation found that it would have been difficult for prison staff to have foreseen or prevented the man's actions in February. The clinical reviewer concluded that he received a level of care equivalent to that he would have received in the community, with appropriate assessments of his mental health and risk of self-harm and suicide. The investigation identified some deficiencies in induction arrangements at both Pentonville and Brixton and in emergency arrangements at Brixton. We make three recommendations about these matters.

THE INVESTIGATION PROCESS

8. The investigator issued notices to staff and prisoners at HMP Brixton informing them of the investigation and inviting anyone with relevant information to contact him. Two prisoners responded.

9. NHS England commissioned a clinical reviewer to review the man's clinical care in prison.

10. The investigator interviewed a number of staff and prisoners, and obtained all relevant documents from his time in prison. He gave feedback to the Governors of HMP Brixton and HMP Pentonville about the initial findings of the investigation.

11. We informed HM Coroner for Inner South London District of the investigation and we have sent the Coroner a copy of this investigation report.

12. One of the Ombudsman's family liaison officers contacted the man's family to explain the investigation. They did not have any specific issues for the investigation to consider.

13. The man's wife received a copy of the draft report. She raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

HMP PENTONVILLE AND BRIXTON

14. HMP Pentonville is a local prison serving the courts of North London and holds over 1,300 prisoners.

15. HMP Brixton is a resettlement prison for up to 800 medium and low security men in five main residential units. Care UK coordinates healthcare services at the prison with a number of different service providers. A GP service runs from 8.00am until 5.00pm five days a week and nurses are on duty from 7.00am to 7.30pm every day.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Brixton was in July 2013. The Inspectorate found that reception arrangements were poor and first night arrangements inadequate. Insufficient attention was paid to vulnerability and safety issues, with too few staff trained in suicide and self-harm awareness, but levels of self-harm were low and those at risk felt well supported.

Independent Monitoring Board

17. 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 2013, the IMB found that the regularity and quality of induction sessions had faltered during the year.

Previous deaths at HMP Brixton

18. The man's death is the second self-inflicted death at Brixton since 2012. Both were deaths from hanging but there were no other significant similarities.

KEY EVENTS

HMP Pentonville

19. The man was convicted of sexual offences at Green Crown Court on 27 January 2014, after being extradited from Ireland. He was sentenced to five years imprisonment. He was sent to HMP Pentonville and arrived at 6.55pm. A nurse completed an initial health screen at which he told her that this was his first prison sentence. He said he had no feelings of suicide or self-harm. She recorded no serious concerns about his physical health and no mental health issues. She did not consider that he was a current risk of suicide or self-harm.

20. At around 8.45pm, the man went to a cell on A wing, the prison's induction unit. There is no record that he had any further contact with staff that evening, or that staff offered him a first night telephone call. The nature of his offence meant that he would usually have been offered vulnerable prisoner status and kept separate from the general population, but this did not happen.

21. A nurse completed a second healthcare assessment at around 8.30am the next morning. She recorded no concerns about the man's physical or mental health, but offered him advice about giving up smoking. He told a nurse that he had no history or thoughts of harming himself. The nurse concluded that his presentation and demeanour gave no indication that he was at risk.

22. An officer wrote in the man's prison record that he attended a prison induction that morning. The officer later told the investigator that the man received a basic induction to the prison, which explained the rules and regime and how to access facilities and services such as Listeners. (Listeners are prisoners trained by the Samaritans to offer confidential support to prisoners in distress.) The prison was unable to provide any documents that we would have expected to see evidencing his induction, such as a signed prisoner compact (an agreement to follow prison rules).

23. A cell sharing risk assessment (CSRA) dated 28 January indicated that the officer had interviewed the man and concluded that he was not a risk of violence towards a cellmate and could live in a shared cell. This decision was signed off under the officer's name and authorised by a doctor. The officer told the investigator he could not remember interviewing the man and denied completing or signing the CSRA. The acting Head of Healthcare found no record of anyone by the name of the doctor working at Pentonville and confirmed that a doctor did not see the man on 27 or 28 January. We brought this matter to the attention of the Governor who has initiated an internal investigation.

24. On the morning of 28 January, a member of staff realised that the man should have been classed as a vulnerable prisoner and, at 10.41am, he moved to a cell on F wing, a unit for vulnerable prisoners. A prison chaplain met him at around 3.40pm. The chaplain did not have any concerns about him from their meeting.

25. The man remained on F wing and there were no meaningful entries in his prison record while he was there. He had no contact with healthcare staff. On 30 January, he moved to a different cell on the wing. The reasons for the move are not recorded.

26. On 5 February, at around 11.00am, a nurse assessed the man as medically fit to transfer to another prison. At 12.15pm the next day, he transferred to HMP Brixton. There is no record of when staff told him that he was moving from Pentonville. A member of the prison's offender management unit told the investigator that prisoners usually receive a letter about transfers the evening before they move.

HMP Brixton

27. The man arrived at Brixton at 1.36pm on Thursday 6 February. An officer met him in the prison's reception and allocated him a single cell on G Wing, the vulnerable prisoners unit. An officer gave him a first night pack, which also contained tobacco.

28. An officer interviewed the man in the prison's reception. He told the officer that it was his first time in prison and that he was pleased to have transferred to Brixton, but was apprehensive. The officer recorded that he had no feelings of suicide or self-harm. He completed a cell sharing risk assessment and concluded that he was not a risk to other prisoners.

29. A nurse reviewed the man and recorded no concerns about his physical or mental health. He told the nurse that he was not taking any medication and had no thoughts of suicide or self-harm. He declined to give his permission for healthcare staff to obtain his community medical records. The reason for his refusal was not recorded. The nurse concluded that he was mentally stable.

30. The man went from reception to G wing at around 3.45pm. An induction orderly (a prisoner who helps new arrivals) spoke to him shortly after he arrived on the wing. The orderly told the investigator that the man did not seem depressed and did not indicate any intention to harm himself. He said that the man signed up for a two-day wing induction due to begin the next week.

31. The investigator interviewed three prisoners who had spoken to the man on 7 February. One prisoner thought that he had seemed slightly confused about life in prison, but all three said that he did not appear upset or anxious.

32. At around 5.00pm that afternoon, an officer went to see the man after another prisoner told him that he was not feeling well. The officer spoke to him about his sentence and gave him some tobacco. He told the officer that he had been unable to use the prison telephone (to make a telephone call to outside the prison) and was unsure how the system worked. The officer told him that he would now have to wait until the next week as the telephone PIN-phone

clerk would need to update his records on the system and she had left for the day. (Prisoners are given an individual PIN to use the telephone system and the numbers they want to call have to be authorised. The PIN clerk told the investigator that Pentonville had activated his phone account and entered his authorised numbers on 5 February. She had transferred his telephone numbers at 12.07pm on Friday 7 February, so he should have been able to make telephone calls.)

33. On 8 February, a nurse reviewed the man on G wing. He told her that he had seen a GP in Ireland after experiencing heart palpitations, and wanted to see a prison GP at Brixton to discuss this again. She took his medical observations. His blood pressure was high at first but normal on a second reading, so she took no further action. She did not refer him to a GP as he had requested.

10 February

34. Prisoner A, a prisoner on G wing, told the investigator that he had heard that some prisoners had stolen property from the man and assaulted him on 10 February, giving him a black eye. He said he could not provide the name of the person who had told him this, because they were a Listener. He also told the investigator that another prisoner had told two officers that the man was intending to kill himself. Again, he was unable to name the prisoner and no other prisoner came forward to say that they had told the officers this. Our investigation found there was no evidence to support what he had said and the post-mortem examination did not find he had a black eye or other unexplained injuries.

35. Prisoner B, another prisoner who lived on G wing, told the investigator that some other prisoners had seen the man crying on 10 February. He was unable to say who these prisoners were and no other prisoners told the investigator this. We found no other evidence that he had been upset that day.

36. Another prisoner told the investigator that he had spoken to the man on the evening of 10 February. He said that he had appeared normal and gave no indication that he had any thoughts of harming himself.

37. The two prisoners who shared a cell next to the man told the investigator that they had both said goodnight to him that evening and he had not indicated that he was upset or had any concerns. They said they heard nothing else from his cell during the night.

38. There were no entries in the man's prison records at the time to show that staff had any concerns about him.

39. At around 6.00am, an operational support grade (OSG) said she counted the prisoners by looking into their cells. She told the investigator that she could not specifically recall seeing the man that morning but that she had not had

any concerns about any of the prisoners on the wing when she carried out the check.

40. At around 7.30am, the OSG handed over to an officer who was starting the morning shift. The officer told the investigator that the OSG did not identify any concerns and had told her that the wing had been quiet overnight.

41. At 8.03am, while unlocking cells on G wing, an officer looked through the observation panel on the man's cell door and saw him hanging from the cell window bars by a ligature made of a thin cord. He immediately went into the cell and shouted 'code one' (Brixton's code for a medical emergency). He said that he could not recall whether he had used his radio and his first priority was to get into the cell to support the body. He found that the man was unresponsive. Another officer, who was also unlocking cells on the wing at the time, responded to the officer's call. He arrived seconds later and cut the ligature. The officers placed him on the bed but could not find any signs of life.

42. A custodial manager and a Senior Officer (SO) heard the officer shouting and arrived shortly afterwards. The custodial manager advised the officers to place the man on the floor and begin cardiopulmonary resuscitation (CPR). The officers moved him and an officer started chest compressions. The custodial manager asked the SO to make a code one radio call to request an ambulance. The control room log shows that the SO radioed the code one at 8.05am.

43. Two nurses arrived with emergency equipment about a minute later after hearing the code one radio call. They took over the resuscitation attempt from the officer. Another nurse joined them shortly afterwards. One nurse was unable to clear the man's airway. The nurses attached a defibrillator (a life-saving device that gives the heart an electric shock in some cases of cardiac arrest) but this did not work. The custodial manager asked an officer to bring another defibrillator from the wing office. The nurses attached the second defibrillator, but it did not detect a shockable heart rhythm, so they continued giving him chest compressions.

44. The duty governor heard the code one call over the radio and arrived at the cell at 8.09am. He radioed the communication room to check that they had called an ambulance, but the staff said they were waiting for further details. He told them to call an ambulance immediately.

45. A prison GP arrived shortly afterwards. After examining the man, she found no signs of life and confirmed that rigor mortis had set in. The doctor pronounced him dead at 8.14am.

Support for staff and prisoners

46. The duty governor debriefed the staff involved in the emergency response before they left the prison and ensured they were offered support.

47. Prisoners on G wing were offered support after the man's death. Those being monitored as at risk of suicide or self-harm were reviewed in case they had been adversely affected by the news.

Family Liaison

48. The man wife lived in Ireland and the prison arranged for the Irish police to inform her of his death. The prison appointed a family liaison officer to remain in contact with his family after his death and to help with arrangements. In line with national guidance, the prison contributed to the cost of the funeral and the repatriation of his body to Ireland.

Post-mortem

49. A post-mortem examination found that the man had died from hanging.

ISSUES

Clinical care

50. The clinical reviewer concluded that the man's standard of health care in prison was equivalent to that he could have expected to receive in the community. His view was that staff could not have predicted or prevented his death. He also noted that he had had an appropriate risk assessment, including a mental health and suicide risk assessment, five days before his death.

Reception and induction

51. Prison Service Instruction (PSI) 74/2011 sets out the mandatory requirements when prisoners first arrive and are inducted into custody. Among these requirements are that prisoners should be interviewed on their first night, and assessed to identify any risk they might pose to themselves or others. They should also receive information about prison life and be allowed to make a telephone call.

52. Shortly after the man arrived at Pentonville on 27 January, a nurse assessed him and found no risk of suicide or self-harm. However, there is no record that any other staff interviewed or supported him that evening or that they offered him a phone call to let his family know where he was. This is concerning, especially as it was his first prison sentence and he had been extradited from Ireland. Although he arrived at the prison relatively late, which might have made full first night procedures more difficult, this was not rectified the next day and we are not satisfied that he received an adequate induction to prison procedures.

53. The staff at Pentonville did not identify the man as a vulnerable prisoner until the day after he arrived. A cell sharing risk assessment form signed that day, noted that a first night interview had taken place. The officer whose name appears on the form denied interviewing him for the assessment and the name of a doctor on the form appears to have been falsified. This gives little assurance of appropriate early day procedures at Pentonville and the Governor is now investigating the matter.

54. When the man arrived at Brixton, it is clear that he still did not have a full understanding of prison processes. On 7 February, he told an officer that he did not know how to use the prison PIN phone system. It is concerning that, eleven days after arriving in prison, he did not know how to make telephone calls so had not been able to speak to his family since he had been sentenced. He was not offered a telephone call when he arrived at Brixton.

55. While it would be generally reasonable for Brixton, which is a resettlement prison, to expect prisoners who arrive there to have had a full induction at their previous prisons, the man had been in prison only ten days before his transfer. He was due to have an induction at Brixton the week after he arrived. However, particularly as prisoners appear to be arriving at Brixton so

early in their sentence, we consider there is a need to ensure that such prisoners, like him, are aware of basic prison procedures. PSI 74/2011 requires prisoners new to custody and/or new to the establishment to be provided with key information relevant to their first few days in the establishment when they arrive.

56. In their most recent inspection of Pentonville, HM Inspectorate of Prisons found that not all prisoners received a full induction, especially those on F wing. The inspection of Brixton in July 2013 found that improvements were needed in first night arrangements and the IMB also commented that induction was not always effective. We make the following recommendation:

The Governors of Pentonville and Brixton should ensure that first night and induction procedures are delivered in line with PSI 74/2011 and that all newly arrived prisoners receive essential information about prison processes.

Assessment of risk of suicide and self-harm

57. Prisoners regarded as at risk of suicide and self-harm are managed under the ACCT system. Any member of staff can open an ACCT on a person who they think is at risk. Once a prisoner is placed on an ACCT plan they are monitored more closely and are subject to regular case reviews that direct the level of observations dependant on their perceived risk.

58. Staff judgement is fundamental to the ACCT system with staff relying on their experience and skills, as well as national guidance, to determine the risk that a prisoner might pose to themselves. Prison Service Instruction (PSI) 64/2011 states that "all staff who have contact with prisoners must be aware of the triggers that may increase the risk of suicide, self-harm or violence, and take appropriate action". The list of potential triggers includes early days in custody and transferring between establishments.

59. Staff who came into contact with the man asked him about and considered the risk that he posed to himself. In the few days that he was in custody, he had at least seven interviews or assessments with prison and healthcare staff, all of which considered that he was not at risk of self-harm. Our investigation found no evidence to support Prisoner A's claim that the man told officers he was going to kill himself.

60. We consider that staff judgements about the man's risk of suicide and self-harm were reasonable and appropriate. He had given no indication that he was in distress and it would have been very difficult for prison staff to have foreseen or prevented his actions in February.

Emergency response

61. Prison Service Instruction (PSI) 03/2013 requires designated emergency medical response codes to be used, including when a prisoner is found unconscious. It directs that when a medical emergency is called over the

radio network, the prison's control or communications room should call an ambulance immediately.

62. The officer acted quickly when he found the man hanging and immediately went into his cell where he was quickly joined by a colleague, who cut the ligature. The officer then began to attempt resuscitation. However, an emergency medical code was not radioed until 8.05am two minutes after the man was found hanging. The control room did not call an ambulance for a further four minutes, after the duty governor arrived at 8.09.

63. At the time of the man's death, Brixton had a protocol for calling an emergency code which set out that the control room should call an ambulance immediately after a code one emergency. The staff we interviewed said they were aware of the protocol, but it was not followed. The officer who found him had a radio but could not recall why he did not use it to call a code one immediately. When the code one was called the control room, did not call an ambulance for approximately four minutes, as they waited for further information, contrary to the instruction. A nurse told us that she thought staff often waited for a nurse to arrive to assess a prisoner before calling an ambulance. The PSI explicitly states that this should not happen.

64. During the emergency response the first defibrillator was not working. Although the need to find a replacement machine did not contribute to the man's death, there is a need for emergency equipment to be checked regularly to ensure it is functioning correctly. Neither did the failure to call an ambulance earlier affect the outcome for him, but in other circumstances such a delay could be crucial. We make the following recommendations:

The Governor of Brixton should ensure that all staff fully understand and follow the local protocol for the use of emergency codes, and that an ambulance is called automatically as soon as a code is called.

The Governor of Brixton and the Head of Healthcare should ensure that all emergency equipment is checked regularly to ensure that it is in working order.

RECOMMENDATIONS

1. The Governors of Pentonville and Brixton should ensure that first night and induction procedures are delivered in line with PSI 74/2011 and that all newly arrived prisoners receive essential information about prison processes.

2. The Governor of Brixton should ensure that all staff fully understand and follow the local protocol for the use of emergency codes, and that an ambulance is called automatically as soon as a code is called.

3. The Governor of Brixton and the Head of Healthcare should ensure that all emergency equipment is checked regularly to ensure that it is in working order.

ACTION PLAN

No	Recommendation	Accepted/ Not accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Governors of Pentonville and Brixton should ensure that first night and induction procedures are delivered in line with PSI 74/2011 and that all newly arrived prisoners receive essential information about prison processes.	Accepted	**HMP Pentonville** The first night and induction procedures have been reviewed, and changes to the information prisoners receive on induction were put in place in August 2014. This includes a new induction presentation delivered jointly by staff and prisoners. Prisoners are now kept on A wing for 5 days to ensure they complete the full induction programme. Changes to making cells available across the prison have also been implemented to ensure that space can be created each day to ensure cells are available on A wing for new receptions. The first night procedure has been streamlined to ensure that only essential information is given in the first few hours. This new process was communicated out to all staff through functional managers in August 2014. **HMP Brixton** A new First Night & Induction procedure is being designed for implementation in October 2014 in line with PSI 74/2011. Designated First Night cells will be assigned on G wing 2s landing, and procedures set in place to ensure transferred prisoners receive additional support for their first few days at Brixton. This	Target date for completion: 6th Oct Head of Residence & Services. Target date for completion: 6 October 2014 Head of Residence & Services.	

			support will include a interview in reception, a second day welfare check, a process for night staff to check inductees, officer and prison orderly induction presentations, and additional association time. A parallel system will operate on C wing for Cat D prisoners.		
2	The Governor of Brixton should ensure that all staff fully understand and follow the local protocol for the use of emergency codes, and that an ambulance is called automatically as soon as a code is called.	Accepted	**HMP Brixton** In May 2014 a meeting was held with the London Ambulance Service (LAS) to clarify our emergency response codes procedures. A protocol has now been put in place with LAS requesting an ambulance in response to emergency codes 1 and 2. The new system went live in June 2014. Awareness has been raised to staff and managers of the local protocol for the use of emergency codes in May through a Notice to Staff (NTS).	Complete Head of Residence and Services/ Head of Safer Custody/ London Ambulance Service	.
3	The Governor of Brixton and the Head of Healthcare should ensure that all emergency equipment is checked regularly to ensure that it is in working order.	Accepted	The Head of Safer Custody reminded staff in September 2014, through a Notice to Staff (NTS) that it is the responsibility of all wing managers to ensure that the emergency equipment, i.e. Ambuboxes, first aid kits and defibrillators are in working order and are checked weekly. The Head of Safer Custody has also reminded staff in September, through a NTS and daily briefing to complete the wing desk diary. This is an auditable book designed to ensure various tasks are completed daily and signed for. A new section has been added to the desk diary to audit the checking of emergency equipment.	Target date for completion: 9 October 2014 Head of Safer Custody.	