

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Stefano Brizzi a prisoner at HMP Belmarsh on 5 February 2017

**A report by the Prisons and Probation Ombudsman  
Nigel Newcomen CBE**

## 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*



© Crown copyright 2015

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit [nationalarchives.gov.uk/doc/open-government-licence/version/3](http://nationalarchives.gov.uk/doc/open-government-licence/version/3) or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: [psi@nationalarchives.gsi.gov.uk](mailto:psi@nationalarchives.gsi.gov.uk).

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

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.

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

Mr Stefano Brizzi died at HMP Belmarsh on 5 February 2017. He was 50 years old. I offer my condolences to Mr Brizzi's family and friends.

Mr Brizzi was serving a life sentence for murder and it was his first time in prison. He was finding it difficult to come to terms with his crime and his long sentence, but appeared to have become more settled in the weeks prior to his death. Mr Brizzi made a sudden and determined attempt to kill himself, and we consider it would have been difficult for staff to have prevented his death. However, we are concerned that potentially significant information about Mr Brizzi's risk of suicide and self-harm was not recorded or shared appropriately.

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

**Richard Pickering**  
**Deputy Prisons and Probation Ombudsman**

**October 2017**

## Contents

Summary .....	1
The Investigation Process .....	3
Background Information .....	4
Key Events .....	6
Findings.....	11

# Summary

## Events

1. On 11 April 2016, Mr Stefano Brizzi was remanded to HMP Belmarsh for the alleged murder of a police officer. It was his first time in prison. The person escort record (PER) form mentioned that he had made threats to kill himself if sent to prison. He told reception staff he had no thoughts of suicide or self-harm. Staff did not start suicide and self-harm prevention procedures (known as ACCT) but he was located in the healthcare centre for further assessment.
2. On 12 April, Mr Brizzi was assessed by the psychiatrist, who noted that there was no evidence of psychosis, depression, or thoughts of self-harm, but that he should continue to be monitored in the healthcare centre.
3. On 4 May, Mr Brizzi moved from the healthcare centre to a standard prison wing, houseblock 3. He moved to a single cell on houseblock 2 on 19 June.
4. On 6 December, officers found a noose in Mr Brizzi's cell during a cell search. Staff started ACCT procedures and he was moved back to the healthcare centre. His risk of harm was assessed as raised. Mr Brizzi said he did not have any thoughts of suicide but he made the noose because he was feeling frustrated and was anxious about his forthcoming trial. At an ACCT review later that day, a nurse lowered his risk.
5. On 7 December, Mr Brizzi was assessed by a psychiatrist who recorded that he had no signs of a mental health illness. Mr Brizzi returned to houseblock 2 from the healthcare centre. He continued to be monitored under ACCT procedures and his risk of suicide and self-harm continued to be assessed as low.
6. On 12 December, Mr Brizzi was sentenced to life imprisonment, with a minimum tariff of 24 years. The trial judge contacted the prison to say that Mr Brizzi should be monitored as he was concerned that he would harm himself. ACCT monitoring continued, no further concerns were noted, and Mr Brizzi's risk continued to be assessed as low. ACCT monitoring stopped on 28 December.
7. On 5 February 2017 at approximately 9.40am, Mr Brizzi was found hanging from the light fitting in his cell. He had used a plaited sheet as a ligature. Staff briefly attempted cardiopulmonary resuscitation (CPR) but he had been dead for some time and his body was stiff due to the presence of rigor mortis. Paramedics attended and confirmed death at approximately 10.10am.
8. After Mr Brizzi's death, it emerged that staff had found some documents in his cell around two weeks prior to his death. The documents indicated that he was preparing a last will and testament. No one recorded this information at the time.

## Findings

9. We found that Mr Brizzi was adequately supported when he was monitored under ACCT procedures in December. We consider that the ACCT paperwork was thoroughly completed, reviews were held at the correct frequency and were

attended by relevant staff, and the decision to stop ACCT monitoring on 28 December was reasonable.

10. We found that information relating to the discovery of documents in Mr Brizzi's cell, which may have indicated he had thoughts of taking his own life, was not recorded or shared appropriately.
11. We found that the initial emergency response to finding Mr Brizzi hanging in his cell was incorrect. An officer pressed the general alarm rather than calling a code blue over the radio to tell the control room to call an ambulance. While the delay in calling the ambulance may not have affected the outcome for Mr Brizzi, it could be critical in other similar incidents.
12. We found some inconsistency in the support offered to members of staff following Mr Brizzi's death.

## **Recommendations**

- The Governor should ensure that when staff become aware of potentially significant information relating to a prisoner's wellbeing, this is properly recorded and, where necessary, disseminated appropriately.
- The Governor should ensure that staff radio the correct emergency code immediately when faced with a situation where a prisoner is not breathing or unconscious so that an ambulance can be called without delay.
- The Governor should ensure that all staff are provided with formal support from the prison following a death in custody

## The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Belmarsh informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
14. The investigator visited Belmarsh on 12 February 2017. She obtained copies of relevant extracts from Mr Brizzi's prison and medical records.
15. NHS England commissioned a clinical reviewer to review Mr Brizzi's clinical care at the prison.
16. The investigator interviewed two prisoners and 12 members of staff at Belmarsh. The clinical reviewer interviewed three members of healthcare staff separately at Belmarsh. The interviews took place between February and July 2017.
17. We informed HM Coroner for Southwark of the investigation, who sent us copies of the post-mortem and toxicology reports. We have sent the coroner a copy of this report.
18. One of the Ombudsman's family liaison officers contacted Mr Brizzi's next of kin (friend) to explain the investigation and to ask if he had any matters he wanted the investigation to consider. Mr Brizzi's friend asked if Mr Brizzi had been appropriately monitored by prison staff.
19. Mr Brizzi's next of kin received a copy of the initial report. They did not raise any concerns regarding factual accuracy of this report.

# Background Information

## HMP Belmarsh

20. HMP Belmarsh is a high security and local prison serving the courts of South East London and South West Essex. It holds approximately 900 men. Oxleas NHS Foundation Trust provides healthcare services. There is 24-hour healthcare cover and a 32-bed inpatient unit.

## HM Inspectorate of Prisons

21. The most recent inspection of HMP Belmarsh was in February 2015 shortly before healthcare services transferred to Oxleas. Inspectors reported that primary mental health services and toilet and shower facilities in the inpatient unit required improvement. Most nursing staff provided good care and interacted well with patients. The safer custody team was impressive and well-motivated. Care for prisoners managed under ACCT procedures was reasonable and most reviews were multi-disciplinary. Prisoners on ACCT felt supported.

## Independent Monitoring Board

22. 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 June 2016, the IMB reported that its greatest concern was whether the prison was adequately staffed and the low morale of officers. Frequent changes to the regime were mainly due to staff shortages and resulted in reduced access for prisoners to showers, telephone calls, social time and planned activities.
23. The IMB noted several improvements to healthcare services since Oxleas took over in April 2015. In particular, access to psychological therapy and secondary mental health services had increased.

## Previous deaths at HMP Belmarsh

24. Mr Brizzi's death was the third self-inflicted death at Belmarsh since July 2015. Our investigation into one of the previous deaths found that staff did not immediately radio the correct emergency code.

## ACCT

25. 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.
26. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

27. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

## Key Events

28. Mr Stefano Brizzi was a high profile prisoner, who was serving a life sentence with a minimum tariff of 24 years, for murdering a police officer and dismembering his body in an attempt to conceal it. He was sentenced for the offences in December 2016. He had no previous convictions and this was his first time in prison.
29. Mr Brizzi was remanded to HMP Belmarsh on 11 April 2016. His person escort record (PER) stated that he had made threats to kill himself and had been on constant watch in police custody. He was assessed by an officer in the first night centre. He told the officer that he had no thoughts of suicide or self-harm. Despite the self-harm warning on Mr Brizzi's paperwork, the officer did not start suicide and self-harm monitoring (known as ACCT) but referred him for a medical assessment.
30. A nurse and a prison GP assessed Mr Brizzi in relation to his physical health. He said he was on medication for HIV and Hepatitis C and he had brought the medication to prison with him. The GP prescribed the relevant medication in line with the doses Mr Brizzi had with him. Mr Brizzi was assessed by the nurse in relation to his mental health. He told her that he suffered from psychosis as a result of dependency on crystal meth and that he heard voices. She referred him to the psychiatrist and admitted him to the healthcare centre. ACCT procedures were not considered necessary.
31. On 12 April, a psychiatrist saw Mr Brizzi. He told her about his family background, saying that his family were in Italy and had found it difficult to deal with his homosexuality, as they were very religious. He said that he had obtained good academic qualifications and had worked in computing and web design for a number of years. He said that he became addicted to crystal meth when he was around 40 years old and, as a result of ongoing misuse, he had lost his job in 2014. He told her that he was being treated for HIV and hepatitis C and had also previously been supported by psychiatric and psychological services due to his drug misuse. She assessed that he was a bright, articulate man with drug addiction problems but there was no evidence of psychosis. She also recorded that there was no evidence of depression or thoughts of self-harm but his general health should continue to be monitored in the healthcare centre.
32. Mr Brizzi remained in the healthcare centre and there were no concerns recorded about his physical or mental health. He moved onto houseblock 3, a standard prison wing, on 4 May. He moved to a single cell on houseblock 2 as part of a routine move on 19 June.
33. Between June and October 2016, staff made a number of positive entries in Mr Brizzi's file showing he was proactive in engaging with education and employment. He was regularly attending the prison workshop where he completed work to a high standard and he began teaching mathematics to other prisoners. There were no concerns recorded about Mr Brizzi's conduct during this time and no concerns recorded about his risk of suicide or self-harm.
34. Mr Brizzi's trial started on 19 October. On the second day of the trial, the judge was so concerned about Mr Brizzi's mental state that he was unable to continue

with the day's proceedings. Mr Brizzi was returned to Belmarsh where he was seen by a prison GP. The GP recorded in his medical notes that Mr Brizzi was upset by the things he had heard in court and he told him that he just wanted to go back to his cell to think about things. He recorded no concerns about suicide or self-harm but he prescribed a mild sedative, which Mr Brizzi declined, saying there was nothing wrong with him. However, Mr Brizzi later took diazepam medication to help him through the remainder of the trial.

35. On 14 November, Mr Brizzi was convicted of murder. He was returned to Belmarsh to await sentencing.
36. On 6 December, an officer found a noose made of plaited bed sheet material in Mr Brizzi's cell following a cell search. The search had taken place after a prisoner had told staff that Mr Brizzi had shown him the noose. He was friends with Mr Brizzi. He was sufficiently concerned about the noose to report it to staff, but he did not want Mr Brizzi to know he had reported it so asked that they look for the noose as part of a routine cell search.
37. After the noose was found, a safer custody manager started ACCT monitoring. She completed the Concern and Keep Safe Form at 12.20pm. She interviewed Mr Brizzi and asked him about the noose and why he had it in his cell. Mr Brizzi told her that he had made the noose out of desperation and that he had been experiencing thoughts and fantasies about taking his own life. He said that he was bored and frustrated with the level of activity at Belmarsh and that he was feeling lonely and isolated. He said that he had thrown his life away and she recorded that he was angry with himself and tearful at some points during the interview. Mr Brizzi told her that he was not really serious about using the noose, but he understood that he would need to be monitored. She completed an immediate action plan which included monitoring Mr Brizzi at hourly intervals until the next assessment.
38. The first ACCT case review took place later that day at 5.20pm. The review was chaired by a Supervising Officer (SO), unit manager of houseblock 2, and attended by a nurse. Mr Brizzi's risk of harm was assessed as raised. The SO and nurse agreed that he should be moved to healthcare for further assessment and monitoring until after his sentencing date. Mr Brizzi was unhappy with the decision to move him to healthcare and said that he wanted to stay on houseblock 2.
39. The next ACCT case review took place at 6.20pm in the healthcare centre; it was chaired by a nurse. Mr Brizzi repeated to the nurse that he did not have any thoughts of harming himself and that he was frustrated about the court case and not having access to his money. He said he was depressed and requested sleeping tablets. The nurse recorded that Mr Brizzi was frustrated about the restricted regime in healthcare. He reduced Mr Brizzi's risk of harm to low and he was monitored at hourly intervals throughout the night.
40. On 7 December, Mr Brizzi had a mental health review with a psychiatrist to assess his fitness for discharge from the healthcare centre and a return to houseblock 2. Mr Brizzi told him that he was finding it difficult to adjust to life in prison but he was coming to terms with it. He said that he found the trial very difficult and admitted to having thoughts of suicide. He added, however, that he

did not intend to use the noose, he did not want to end his life, and he would not even know how to hang himself. He spoke about planning for the future in prison and his acceptance of the situation. Mr Brizzi said that being in healthcare was making him feel worse and that he wanted to return to houseblock 2. The psychiatrist recorded that there were no signs of an acute mental illness or clinical depression. He made the decision to discharge Mr Brizzi from the healthcare centre but made a referral to the mental health in-reach team for ongoing support. Mr Brizzi was returned to houseblock 2 later that day. His risk was assessed as low and he was monitored at hourly intervals.

41. On 12 December, Mr Brizzi was convicted of murder and sentenced to life imprisonment with a minimum term of 24 years. The sentencing judge's office contacted Belmarsh by email to request confirmation that Mr Brizzi would be monitored on his return to the prison after sentence. The judge was concerned because Mr Brizzi had previously said that he would not be able to serve a life sentence. The safer custody manager replied to the judge, letting him know that Mr Brizzi was being monitored under ACCT procedures.
42. On 13 December, Mr Brizzi's next ACCT review was brought forward following his sentence on the previous day and he met a mental health nurse for the first time. The nurse recorded that Mr Brizzi presented well and said that he was relieved that the court case was over. Mr Brizzi also said that he was looking forward to planning the rest of his life. The nurse challenged Mr Brizzi at this meeting by saying that those who may have suicidal thoughts often pretend that all is well while they are putting plans in place to end their life. Mr Brizzi assured him that this was not the case with him and he would talk to staff if he felt like harming himself.
43. No further concerns were raised about Mr Brizzi's risk of suicide and self-harm and ACCT monitoring stopped on 28 December. He appeared more settled following sentence. He reported that he had good support within the prison and he was looking forward to focusing on education and employment. He also applied to the Samaritans to be a Listener (a prisoner trained by the Samaritans to support other prisoners).
44. Mr Brizzi was accepted by the Samaritans to be a Listener. He started his course in January 2017 and was due to qualify as a Listener on 6 February. During one of his training sessions, he allegedly asked other prisoners if they knew of any Listeners having taken their own life. The Samaritans trainer told the investigator that she was not aware that Mr Brizzi had asked this. She did say, however, that she would not have reported this information to prison staff if she had been made aware of it. She said that anything said to the Samaritans or a Listener is confidential under the Samaritans' values and therefore cannot be shared with others, even if there is a risk that someone intends to take their own life.
45. On 24 January, two officers found some documents in Mr Brizzi's cell during a routine cell search. The documents included an envelope marked "in case of death". The officers were concerned as they knew Mr Brizzi had previously been monitored under ACCT procedures. One officer told the investigator that he showed the paperwork to his SO. The SO opened the envelope and found a

note with next of kin details and a list of officers' names. She asked him to photocopy the documents in the safer custody office, which he did.

46. The SO then spoke to Mr Brizzi in the presence of the two officers. Mr Brizzi said that he was preparing his Will, as he knew he was not in good health and was likely to be spending the rest of his life in prison. He said he did not have any thoughts of suicide or self-harm. He said that he had the list of officers' names as it helped him to remember who they all were. She spoke to him about the noose he had previously made and reminded him about support mechanisms if he should need them. She said that he appeared relaxed and honest and she was satisfied with the answers he gave her. One officer said that he and his colleague were also satisfied with Mr Brizzi's answers and had no concerns. The officers returned Mr Brizzi to his cell.
47. The SO spoke to a safer custody officer to tell her that she had interviewed Mr Brizzi, and they both agreed that he did not need to be interviewed again by safer custody. No one recorded the discovery of the documents or the content of the interview with Mr Brizzi. No one recorded the contact between the SO and safer custody colleagues.
48. On the evening of 4 February, an officer locked Mr Brizzi in his cell after dinner. He said that Mr Brizzi said goodnight to him in a normal manner and he had no concerns about him. During the night, a night patrol officer carried out security checks on Mr Brizzi by looking through the door observation panel at 8.00pm, 10.00pm, 12.00am and 5.00am. (There was no formal requirement for him to make welfare checks on Mr Brizzi or to get a response from him as he was not being monitored under ACCT procedures.) He told the investigator that he had no concerns about Mr Brizzi and he could see him in his bed when he last checked on him around 5.00am on the morning of 5 February.
49. At approximately 9.40am on 5 February, Officer A was unlocking the prisoners for exercise. He looked through the observation panel on Mr Brizzi's cell door and noticed it was covered. He opened the door and saw Mr Brizzi hanging from the light fitting. He closed the door and ran to the landing below to call his colleague. They went back to Mr Brizzi's cell and Officer A pressed the general alarm. They went into Mr Brizzi's cell and were quickly joined by a SO, who had responded to the general alarm. Staff radioed a code blue (an emergency medical code used to alert the control room to call an ambulance as a prisoner is not breathing or is unresponsive) at 9.47am. Officer A and the SO lifted Mr Brizzi while Officer B cut the ligature from the light fitting. They placed Mr Brizzi on the floor and Officer B cut the ligature from around his neck. The SO attempted to carry out cardiopulmonary resuscitation (CPR) but Mr Brizzi's body was stiff due to the presence of rigor mortis.
50. The in-charge governor arrived at the cell. He agreed that Mr Brizzi had been dead for some time and he also noticed some paperwork laid out on his bed. He said that no one else should go into the cell, including healthcare staff, as he knew that any resuscitation attempt would be ineffective and he wanted to preserve evidence at the scene. He said they should wait for the paramedics to arrive and confirm death. The paramedics arrived at 9.55am and confirmed Mr Brizzi's death at 10.10am.

51. Mr Brizzi left a note saying goodbye to his family. He wanted his family to know that he was at peace, he was happy to die, and he was sorry for their pain.

### **Contact with Mr Brizzi's family**

52. Mr Brizzi had left some paperwork in his cell providing the name of a friend to be contacted in the event of his death. He had also named the same friend as his next of kin on his prison records and recent ACCT document. At about 3.40pm on 5 February, a SO and the appointed family liaison officer visited Mr Brizzi's friend at home and informed him of Mr Brizzi's death. His friend then phoned Mr Brizzi's brother in Italy to inform him of his brother's death. The prison contributed to the cost of Mr Brizzi's funeral, in line with Prison Service instructions.

### **Support for prisoners and staff**

53. After Mr Brizzi's death, the duty governor debriefed staff involved in the emergency response to offer support and ensure they had the opportunity to discuss any issues arising. The staff care team also offered support.
54. The Governor posted a notice for prisoners informing them of Mr Brizzi's death and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Brizzi's death.

### **Post-mortem report**

55. The post-mortem report gave the cause of death as hanging. Toxicology tests detected no alcohol or illicit drugs in Mr Brizzi's body. An exact time of death could not be established.

# Findings

## Assessment of risk of suicide and self-harm

56. Prison Service Instruction (PSI) 64/2011, which covers safer custody, lists a number of risk factors and potential triggers for suicide and self-harm. A charge of murder is a significant risk factor for suicide in itself. It was Mr Brizzi's first time in prison and he faced a long sentence. He arrived at Belmarsh on 11 April 2016 with a self-harm warning but staff decided that he did not need to be monitored under suicide and self-harm prevention procedures (ACCT) although he was located in healthcare for further assessment. Despite not being on an ACCT during his time in healthcare, we consider that Mr Brizzi was appropriately monitored and supported. We consider that, by the time he transferred to a standard prison wing on houseblock 3, his risk of suicide and self-harm had been adequately assessed.
57. When a noose was found in Mr Brizzi's cell on 6 December, staff correctly opened an ACCT. We found that the concern and keep safe form completed by the safer custody manager was thorough and informative in relation to the nature of his risk and her reasons for opening the ACCT. We found that the first ACCT case review, held later that day, was attended by the appropriate staff and the decision to assess Mr Brizzi's risk of harm as raised was a reasonable one. Although a nurse reduced his risk of harm quite quickly, we are satisfied that Mr Brizzi was adequately monitored and that a psychiatrist appropriately assessed his mental health before he was discharged from the healthcare centre the following day.
58. ACCT monitoring remained in place for more than two weeks after Mr Brizzi's sentencing. Reviews were held at the correct frequency (including one being brought forward to support Mr Brizzi following his sentencing) and were attended by relevant staff. We consider that the decision to stop ACCT monitoring on 28 December was a reasonable one, given that Mr Brizzi appeared more settled and was making plans for the future. Overall, we consider that Mr Brizzi was adequately supported while he was monitored under ACCT procedures between 6 and 28 December.

## Record keeping and sharing of information

59. After Mr Brizzi's death, it emerged that staff had found documents in Mr Brizzi's cell during a routine cell search some two weeks before his death. The documents indicated that he was preparing a last Will and testament. Although staff spoke to Mr Brizzi at the time to establish whether he had any plans to end his life, we are concerned that no one recorded the discovery of the documents or the subsequent conversation with Mr Brizzi.
60. A SO said that she spoke to an officer and the safer custody manager and that she asked an officer to put an entry in the observation book about the documents he found. She also said that she wrote in the observation book alongside the officer's entry, but there is no evidence of such entries being made. The officer told the investigator that he was not asked to make a record of the incident, although he did interview Mr Brizzi and agreed that there was no reason to be concerned about him. Another officer accepts that she spoke to the SO, but said

she was unaware that Mr Brizzi had said he was writing his Will. The safer custody manager said she had no knowledge of the incident at all until after Mr Brizzi's death. The lack of a written record, and the conflicting accounts at interview, has made it difficult to establish exactly what action was taken following the discovery of these documents, including what information was shared and with whom.

61. On balance, we do not consider that these documents represent a missed opportunity to prevent Mr Brizzi's death. We are satisfied that the SO's actions in speaking to Mr Brizzi, along with two other officers, was reasonable in the circumstances and there is sufficient evidence that those who spoke to him were satisfied with his responses. We do however find that it was an error not to record any of this information. Had the information been properly recorded and shared at the time, consideration could have been given to opening an ACCT to monitor Mr Brizzi more closely. We make the following recommendation:

**The Governor should ensure that when staff become aware of potentially significant information relating to a prisoner's wellbeing, this is properly recorded and, where necessary, disseminated appropriately.**

### Emergency response

62. When Officer A found Mr Brizzi hanging in his cell, he closed the door and ran to tell Officer B what he had seen. He should have used his radio to call an emergency code blue, which tells the control room that a prisoner is not breathing or is unresponsive and that they should call an ambulance immediately. When he told Officer B what he had seen, Officer B told him to press the general alarm.
63. Officer A had only been working as a prison officer for eight months and had never dealt with an emergency of this kind. He said that he closed Mr Brizzi's cell door as he was aware that prisoners had been unlocked and he did not want anyone else to see Mr Brizzi hanging. He said he was very shocked by what he had seen, so he went to tell someone as quickly as he could. Both officers should have known to radio a code blue emergency, rather than raising the general alarm. As a result, staff who attended the incident did not know that it was a medical emergency and there was a delay of seven minutes between Officer A finding Mr Brizzi and the correct emergency code being called.
64. We accept that both officers were in shock and, from their interviews with the investigator, we know that they are both aware of the importance of calling the correct emergency code. We also accept that Mr Brizzi had been dead for some time so the delay in calling an ambulance did not affect the outcome for him. But we are concerned that such a delay could be of significant importance in other cases and we therefore make the following recommendation:

**The Governor should ensure that staff radio the correct emergency code immediately so that an ambulance can be called without delay.**

## Staff Support

65. The SO felt that she was poorly treated and criticised by prison managers. She was moved away from her usual place of work on houseblock 2 and she said that the deputy governor told her that she was a risk to vulnerable prisoners. She said that this had an impact on her emotional wellbeing, to the extent that she was unable to attend work for a number of weeks.
66. We found that there was inconsistency in the support offered to staff following Mr Brizzi's death. Although most members of staff said they felt supported and knew where to go for support if they needed it, some were still struggling with their involvement in the incident and did not feel adequately supported. We make the following recommendation:

**The Governor should ensure that all staff are provided with formal support from the prison following a death in custody.**

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations