Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Murphy a prisoner at HMP Brixton on 4 May 2018

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T I 020 7633 4100
F I 020 7633 4141

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*

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 Michael Murphy died of a lack of oxygen to the brain caused by a cardiac arrest on 4 May 2018 while a prisoner at HMP Brixton. Mr Murphy was 45 years old. I offer my condolences to his family and friends.

The cause of Mr Murphy's cardiac arrest is unascertained. The post-mortem report concluded that a toxicological or a natural cause was a possibility.

Mr Murphy's clinical care was equivalent to that which he could have expected to receive in the community. However, I am concerned that healthcare staff missed an opportunity to identify the extent of Mr Murphy's substance misuse.

Healthcare staff appropriately started suicide and self-harm prevention procedures when Mr Murphy arrived at Brixton but prison staff did not operate some aspects of the procedures appropriately. I am satisfied, however, that this did not affect the outcome for Mr Murphy.

There were delays in the emergency response on the morning that Mr Murphy was found unresponsive in his cell. The officer who found him did not have a radio and had to ask a prisoner to alert staff. Neither the officer nor the other prison staff who responded, tried to resuscitate Mr Murphy. It was not until a nurse arrived that anyone started resuscitation attempts.

Despite a comprehensive substance misuse strategy, I am concerned about the availability of illicit substances at Brixton. Mr Murphy was seemingly able to obtain PS after being at the prison for less than a week. The prison will need to reassess their current approach in line with the Prison Service's recently published Prison Drugs Strategy.

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

Sue McAllister CB
Prisons and Probation Ombudsman **September 2019**

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Summary

Events

1. In November 2017, Mr Michael Murphy was remanded to HMP Wandsworth, charged with burglary. He had a history of mental health and alcohol misuse problems and used psychoactive substances (PS) in prison.

2. On 24 April 2018, Mr Murphy was moved to HMP Brixton. At an initial health screen, a nurse started suicide and self-harm procedures (known as ACCT) after Mr Murphy said that he felt suicidal after the recent death of his brother. There is no evidence that healthcare staff checked the prison's electronic medical record for historical information despite Mr Murphy reporting previous substance misuse.

3. Mr Murphy's cellmate told the investigator that Mr Murphy frequently smoked PS. He said that around two days before Mr Murphy went to hospital, he collapsed in their cell after smoking PS. There is no record that prison or healthcare staff at Brixton knew about Mr Murphy's PS use.

4. At 9.07am on 29 April, Mr Murphy collected his medication from a nurse and did not report any concerns. Between 9.37am and 9.50am, CCTV footage shows several prisoners going in and out of Mr Murphy's cell. At 9.55am, an officer went to complete an ACCT check on Mr Murphy and found him unresponsive. He did not have a radio so he asked a prisoner to notify staff. Another officer arrived and radioed a medical emergency code blue at 9.58am. Records show that officers did not start cardiopulmonary resuscitation (CPR).

5. At 10.00am, a nurse arrived and saw that Mr Murphy appeared to have stopped breathing. She asked for emergency medical equipment and started CPR. A custodial manager arrived quickly with an emergency medical bag but officers had difficulty finding a defibrillator. At 10.26am, paramedics noted that Mr Murphy had a steady pulse but was unable to breathe on his own and they took him to hospital. Two officers went with him and did not use restraints.

6. On 30 April, a prison manager and the Head of Healthcare visited the hospital. A consultant told them that Mr Murphy was critically ill and that they did not know what had caused his cardiac arrest.

7. On 1 May, a member of prison staff submitted an intelligence report stating that they had overheard a prisoner say that Mr Murphy had smoked a large amount of PS in a vape (an electronic cigarette). Intelligence records also show that the prisoners who entered Mr Murphy's cell before prison staff found him unresponsive might have supplied him with PS.

8. At 12.22pm on 4 May, hospital doctors pronounced that Mr Murphy had died. His family were with him at the hospital.

9. The post-mortem report found no injuries or natural disease that would have caused or contributed to Mr Murphy's death. Toxicological analysis of his blood did not find any illicit substances but a sample taken before he was admitted to hospital was not made available to the toxicologist. The report concluded that the cause of Mr Murphy's cardiac arrest was unascertained.

Findings

10. The clinical reviewer concluded that the care that Mr Murphy received at HMP Brixton was equivalent to that which he could have expected in the community. However, we are concerned that healthcare staff missed an opportunity to identify the extent of Mr Murphy's substance misuse and to offer him support.

11. Brixton has a comprehensive substance misuse and PS strategy to help reduce the supply of and demand for drugs. It includes clear processes for managing and supporting prisoners suspected of misusing drugs. Despite this, it appears that drugs are readily available and Mr Murphy was easily able to obtain PS within days of arriving at Brixton.

12. Mr Murphy was subject to ACCT monitoring when he died. We are concerned that the assessment was not undertaken within 24 hours, the first case review was not multidisciplinary and the caremap was not completed.

13. The officer who found Mr Murphy did not have a radio and had to ask a nearby prisoner to alert staff. As a result, there was a delay of two minutes before a medical emergency code was called.

14. Prison staff should have started CPR as soon as Mr Murphy was found unresponsive rather than waiting for healthcare staff to arrive.

15. We are concerned that healthcare staff did not immediately take an emergency medical bag or a defibrillator to Mr Murphy's cell when they responded to the emergency code.

Recommendations

- The Head of Healthcare should ensure that healthcare staff review a prisoner's existing medical record as part of the initial screening process.
- The Governor should ensure that the key drug issues at Brixton are identified and that the prison's local drug strategy is revised by September 2019 to address these key issues.
- The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including ensuring that:
    - staff conduct an initial assessment and first case review within 24 hours of starting ACCT procedures;
    - healthcare staff always attend the first case review; and
    - prison staff complete a caremap at the first case review.
- The Governor should ensure that all operational staff have access to a working radio.
- The Governor and Head of Healthcare should ensure that all staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including that:
    - prison staff administer basic life support as needed until healthcare staff arrive;

- healthcare staff take all appropriate medical equipment to medical emergencies; and
- all staff know whether defibrillators are located.

- The Governor and Head of Healthcare should ensure that a copy of this report is shared with the following members of staff so that they are aware of the Ombudsman's findings: two nurses; three SO's and two officers.

The Investigation Process

16. The investigator issued notices to staff and prisoners at HMP Brixton informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

17. The investigator obtained copies of relevant extracts from Mr Murphy's prison and medical records.

18. The investigator interviewed five members of staff and two prisoners at Brixton on 3 and 5 July 2018.

19. NHS England commissioned a clinical reviewer to review Mr Murphy's clinical care at the prison. He conducted joint interviews with the investigator on 3 and 5 July.

20. We informed HM Coroner for Inner London South of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

21. The investigator wrote to Mr Murphy's wife to explain the investigation and to ask if she had any matters she wanted us to consider. The solicitor representing Mr Murphy's wife responded but did not ask any specific questions.

22. The initial report was shared with Mr Murphy's wife's legal representative. They did not raise any further issues, or comment on the factual accuracy of the report.

23. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out a factual inaccuracy and this report has been amended accordingly. The action plan is annexed to this report.

Background Information

HMP Brixton

24. HMP Brixton is a medium security resettlement prison in London that holds up to 810 convicted and sentenced adult male offenders. Care UK, an independent company providing health and social care, provides healthcare services. The prison has five wings, including a sex offender unit and a drug recovery unit.

HM Inspectorate of Prisons

25. The most recent inspection of HMP Brixton was in January 2017. Inspectors reported that security arrangements were not effective enough and far too many drugs and mobile phones were entering the prison. They reported that the prison did not have a substance misuse strategy but a strategy which included supply reduction was in an advanced stage of development. (Brixton published a drug strategy later that year.) Inspectors reported that positive rates for mandatory drug testing were high and that prisoners were openly smoking cannabis on the wings.

26. Inspectors reported that the quality of most ACCT documents was poor and there were some dangerous shortcomings in the support and management of those subject to ACCT procedures.

Independent Monitoring Board

27. 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 August 2018, the IMB found that although staff had worked hard to prevent contraband entering the prison, there was still a significant amount of work required to reduce drug abuse. They reported that safer custody meetings were held frequently, and that the quality of ACCTs had, in the main, improved.

Previous deaths at HMP Brixton

28. Mr Murphy was the first prisoner to die at Brixton since May 2016. There have been two deaths since, one from natural causes and one self-inflicted. There were no similarities between Mr Murphy's death and the previous deaths.

Assessment, Care in Custody and Teamwork

29. Assessment, Care in Custody and Teamwork (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. 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 multidisciplinary review meetings involving the prisoner.

30. 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. 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.

Psychoactive Substances (PS)

31. Psychoactive substances (formerly known as 'new psychoactive substances' or 'legal highs') are a serious problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

32. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at that time NPS) and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

33. HM Prison and Probation Service (HMPPS) now has in place provisions that enable prisoners to be tested for specified non-controlled PS as part of established mandatory drug testing arrangements.

Key Events

34. On 18 November 2017, Mr Michael Murphy was remanded to HMP Wandsworth, charged with burglary. (He was subsequently sentenced to three years in prison on 31 January 2018.)

35. Mr Murphy had a history of mental health and alcohol misuse problems which healthcare staff treated with citalopram (an antidepressant) and a detox regime. Prison records show that Mr Murphy used psychoactive substances (PS) and had several altercations with other prisoners at Wandsworth. On 27 March 2018, Mr Murphy tested positive for PS during a random mandatory drug test (MDT), and had 15 days added to his sentence through the disciplinary process.

36. On 13 April, a prison chaplain received a call from Mr Murphy's wife to say that his brother was dying in Ireland. He arranged for Mr Murphy to phone his wife and offered support. On 21 April, another prison chaplain visited Mr Murphy when he was told that his brother had died. He offered support and recorded that Mr Murphy appeared low in mood.

37. On 24 April, Mr Murphy was transferred to HMP Brixton as part of his sentence progression. At reception, he told a Supervising Officer (SO) that his brother had died four days ago and that he would like the counselling that staff had offered him at Wandsworth. He said that he was scared about being in prison and that he had struggled with PS use at Wandsworth. The SO told Mr Murphy that she was going to start suicide and self-harm procedures, known as ACCT, but he did not want her to. She told the investigator that she felt Mr Murphy was vulnerable and shared her concerns with a nurse.

38. At an initial health screen, Mr Murphy told a nurse that he had depression and felt suicidal after the news about his brother. She started ACCT procedures and referred him to the prison's mental health team. Mr Murphy did not report any alcohol or drug misuse problems but said that he had used illicit substances in the past. There is no evidence that she checked the prison's electronic medical record for historical information or that she considered referring him to the prison's substance misuse team. A SO completed an immediate action plan and set Mr Murphy's ACCT observations at one every hour.

39. On 25 April, a nurse saw Mr Murphy for a secondary health screen and noted that he felt low in mood but did not report thoughts of suicide or self-harm. There is no record that the nurse spoke to Mr Murphy about alcohol or substance misuse. Later that day, a SO tried to conduct an ACCT assessment but Mr Murphy refused to engage, and said that he had just woken up. He noted in the ACCT record that staff would try again tomorrow.

40. At 10.24am on 26 April, an occupational therapist who worked in the prison's mental health in-reach team, assessed Mr Murphy. She told the investigator that her role was to complete an initial assessment so a discussion about treatment could take place at a multidisciplinary team meeting on 2 May. She recorded that although Mr Murphy reported using illicit drugs in the past, he said he did not have current issues with drugs and did not require a substance misuse referral. At 2.00pm, a SO recorded that Mr Murphy refused to engage in an ACCT assessment and said that he did not feel like talking.

41. At 4.00pm on 27 April, a SO conducted Mr Murphy's ACCT assessment and recorded that he reported feeling depressed, stressed and paranoid around other prisoners. At 5.10pm, another SO chaired a first ACCT case review and assessed Mr Murphy as a high risk of harm to himself (on a scale of low, raised and high). He kept Mr Murphy's observations at one every hour and asked for a member of mental health staff to attend the next case review. However, there is no record of a caremap.

42. Mr Murphy's cellmate told the investigator that Mr Murphy regularly smoked PS using a vape (an electronic cigarette). He said that around two days before Mr Murphy was taken to hospital, he returned to their cell and found Mr Murphy smoking PS. He said Mr Murphy subsequently collapsed so he put him in the recovery position until he came around. There is no record that prison or healthcare staff at Brixton knew about Mr Murphy's PS use. Another prisoner told us that he helped Mr Murphy fill in a form to the prison's safer custody department as he had issues with other prisoners from the travelling community. There is however no record of this document.

Events on Sunday 29 April to Friday 4 May

43. At 8am, on 29 April, an officer unlocked Mr Murphy's cell door and noted in his ACCT observation record that he was sleeping. Mr Murphy's cellmate told the investigator that when he woke up, he smelt PS and spoke to Mr Murphy about smoking PS in the cell. At 9.00am, an officer conducted an ACCT check and recorded that Mr Murphy was spending time in his cell. At 9.07am, Mr Murphy collected his medication from a mental health nurse. In his prison statement, the mental health nurse said that Mr Murphy appeared well and did not report any concerns. Between 9.37am and 9.50am, CCTV footage shows several prisoners going in and out of Mr Murphy's cell.

44. At around 9.50am, an officer found Mr Murphy's cellmate smoking an illicit item with another prisoner. He said that he was smoking a tea bag as he felt stressed after having an argument with Mr Murphy. The officer decided to complete an ACCT check and arrived at Mr Murphy's cell at 9.55am. He found him on the bottom bunk, lying unresponsive on his left side. He did not have a radio, so he asked a prisoner to notify staff while he tried to get a response from Mr Murphy. Another officer arrived at 9.57am, noticed that Mr Murphy was unresponsive and used a radio to call a medical emergency code blue (which indicates that a prisoner is unconscious or has breathing problems) at 9.58am.

45. A SO arrived with two officers within one minute and checked Mr Murphy's vital signs. She found that he did not have a pulse and instructed staff to move him onto the floor. In the meantime, a prison manager heard the emergency code over the radio network and asked a Custodial Manager (CM) to collect an emergency medical bag and meet her at his cell.

46. At around 10.00am, the first response nurse arrived and saw that Mr Murphy appeared to have stopped breathing. She opened his airway, requested emergency medical equipment and started cardiopulmonary resuscitation (CPR). A nurse arrived shortly afterwards and was followed by the CM, who had an emergency medical bag. After initially having difficulty finding a defibrillator, prison staff found one. A nurse applied the defibrillator which initiated a shock.

47. An ambulance arrived the prison at 10.03am and the first paramedic reached Mr Murphy's cell at 10.09am. Prison staff moved Mr Murphy onto the landing for easy access and paramedics took over resuscitation efforts.

48. A prison manager asked two officers to enter Mr Murphy's cell to look for any obvious signs of drug misuse. They found a work boot containing drug paraphernalia and prescribed medication belonging to another prisoner.

49. Paramedics noticed that Mr Murphy had a black eye and, at 10.26am, recorded that he had a steady pulse but was unable to breathe on his own. At 10.47am, paramedics took Mr Murphy to a hospital in London. Two officers went with him and did not use restraints. Hospital staff admitted Mr Murphy to the Critical Care Unit and conducted a computerised tomography (CT) scan.

50. On 30 April, the prison manager and the Head of Healthcare visited the hospital and met with a consultant and a lead nurse. The consultant informed them that although the CT scan of Mr Murphy's head did not show any sign of trauma, he remained critically ill and they did not know what had caused his cardiac arrest. Prison healthcare staff remained in frequent contact with the hospital for updates about Mr Murphy's condition.

51. On 1 May, a member of prison staff submitted an intelligence report which stated they that had overheard a prisoner say that Mr Murphy had smoked a large amount of PS in a vape. The following day, prison staff searched Mr Murphy's cell with a drugs dog. The dog did not indicate a specific item but showed interest in two cups, one containing a damaged vape, and the other, several extinguished cigarettes. Intelligence records also show that Mr Murphy's cellmate had a history of illicit drug misuse and that the prisoners who entered Mr Murphy's cell before staff found him on 29 April, may have supplied him with PS.

52. At 2.00pm on 3 May, a prison manager visited the hospital to review Mr Murphy's risk assessment. He spoke to hospital staff who confirmed that Mr Murphy's condition was terminal and that they planned on removing his life support system. He reviewed Mr Murphy's ongoing ACCT record, stopped his hourly observations and withdrew escort staff from his bedside to allow his family more privacy. At 12.22pm on 4 May, Mr Murphy died with his family present.

Contact with Mr Murphy's family

53. At 12.10pm on 29 April, a prison manager phoned Mr Murphy's wife and told her that he had been taken to the hospital. At 9.15pm, she appointed an administrator as family liaison officer and a prison manager as her deputy. At 11.03pm, the family liaison officer visited the hospital and introduced herself to Mr Murphy's wife. At 3.25pm on 30 April, she and her deputy visited the hospital and offered support to Mr Murphy's family.

54. At 11.15am on 4 May, the family liaison officer phoned Mr Murphy's wife who told her that Mr Murphy was brain dead. She gave her a phone number to contact her on over the weekend if she needed support. On 8 May, she phoned Mr Murphy's wife and arranged a home visit. Two days later, she and her deputy visited her to discuss the next steps and to offer support. However, a prison manager told the investigator that although Brixton offered to contribute towards

Mr Murphy's funeral in line with national instructions, Mr Murphy's wife told the family liaison officer that the family did not want any support or further contact from the prison.

Support for prisoners and staff

55. On 29 April, a prison manager debriefed staff in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. After Mr Murphy died, a prison manager debriefed the staff involved in the emergency response and the hospital escorts. The staff care team also offered support.

56. The prison posted notices informing other prisoners of Mr Murphy's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Murphy's death.

Post-mortem report

57. The post-mortem report concluded that Mr Murphy died of a hypoxic brain injury caused by a cardiac arrest. It found no injuries or natural disease that would have caused or contributed to Mr Murphy's death. The report stated that the very long period of "down time" between prison staff finding Mr Murphy and the paramedics re-establishing circulation resulted in a hypoxic brain injury (caused by a lack of oxygen to the brain). The report also found that the injury to Mr Murphy's left eye was consistent with an assault or a fall but had no bearing on the cause of death.

58. Post-mortem toxicology test results did not identify any illicit substances but a blood sample taken before his hospital admission was not made available to the toxicologist. The report concluded that the underlying cause of Mr Murphy's cardiac arrest was unascertained and that a toxicological or a natural cause was a possibility.

Events after Mr Murphy's death

59. On 9 May, a member of prison staff submitted an intelligence report which stated that two of the prisoners who entered Mr Murphy's cell on 29 April assaulted him for not paying a PS debt.

Findings

Clinical care

60. The clinical reviewer considered that the overall care that Mr Murphy received at Brixton was equivalent to that which he could have expected to receive in the community. Healthcare staff identified his vulnerability, started ACCT procedures and appropriately referred him to the prison's mental health team.

61. However, we are concerned that healthcare staff accepted too willingly Mr Murphy's assertion that he did not have substance misuse problems. His medical record from Wandsworth was available but staff did not review this information as part of the health screening process. A nurse told the investigator that he did not speak to Mr Murphy about drug misuse or review his medical record because he noticed that he did not report any issues at his initial health screen. This meant that staff missed an opportunity to identify the extent of Mr Murphy's substance misuse and to offer support. We make the following recommendation:

    The Head of Healthcare should ensure healthcare staff review a prisoner's existing medical record as part of the initial screening process.

Illicit substances

62. Following an inspection in January 2017, HM Chief Inspector of Prisons was concerned about the large amount of illicit drugs entering Brixton. Although there are no records that Mr Murphy took illicit drugs at Brixton, intelligence received after he was found unresponsive indicates that he had collapsed two days previously, having smoked PS. At interview, a prisoner told us that drugs, including PS, were readily available at Brixton and that prisoners often used the phrase "man down" to describe a prisoner who had become incapacitated. He also said that bullying and drug-related fights occurred frequently.

63. The post-mortem report did not find PS or other illicit substances in Mr Murphy's system but he had a history of using PS and drug-related paraphernalia were found in his cell. Mr Murphy's cellmate told the investigator that Mr Murphy took PS regularly and intelligence records show that two of the prisoners who entered his cell before he was found by prison staff, had connections with the prison's illicit drug supply. Although we have been unable ascertain what happened in Mr Murphy's cell on 29 April or if he obtained his black eye at that time, we consider it likely that he took PS. An officer found Mr Murphy on the bottom bunk lying on his side, which suggests that the prisoners in his cell may have placed him in this position following a bad reaction to PS.

64. Brixton's drug and alcohol strategy for 2017-18 was in place at the time of Mr Murphy's death, and aimed to reduce the supply of illegal substances, identify prisoners with substance misuse problems, reduce demand, provide interventions and use intelligence to take action against those who brought illicit substances into the prison. The strategy was revised for 2018 – 2019 and includes a strategy specifically for PS which aims to minimise the harm associated with PS.

65. It is a concern that, despite these measures, Mr Murphy was seemingly able to obtain PS easily within a few days of arriving at the prison and suggests that much more needs to be done to tackle the issue of drugs at Brixton.

66. Drug taking and trading is a serious problem across much of the prison estate. Individual prisons are for the most part doing their best to tackle the problem by developing their own local drug strategies. However, the PPO has called for national guidance to prisons from HMPPS providing evidence-based advice on what works. We welcome the fact that such guidance has now been issued, together with a Prison Service strategy to reduce the supply of and demand for drugs in prisons.

67. In relation to reducing the supply of drugs, the new Prison Service strategy says:

> "Every prison is different, and will benefit from tools to assess their specific security needs. We have worked with prisons to carry out Vulnerability Assessments in prisons to build a picture of the security risks and enable establishments to better target their resources to tackle them. This resource will continue to be offered across the estate. The Drug Diagnostic toolkit used for the prisons in the 10 Prisons Project has also proved to be useful in identifying key issues in different establishments and so we will share this for use across the whole estate, supporting prisons to identify where changes could have the greatest impact."

We therefore recommend that:

The Governor should ensure that the key drug issues at Brixton are identified and that the prison's local drugs strategy is revised by September 2019 to address these key issues.

ACCT procedures

68. Prison Service Instruction (PSI) 64/2011 on safer custody contains guidance and mandatory instructions on managing prisoners at risk of suicide and self-harm. It instructs that the first ACCT case review must be held within 24 hours of ACCT procedures being started, ideally immediately after the assessment interview. This is so that the issues that have led to ACCT monitoring can be identified and addressed at an early stage with a member of healthcare present. If the prisoner refuses to be interviewed or is unable to participate in the interview, the ACCT assessor must undertake the assessment based on all available information.

69. When Mr Murphy refused to take part in the ACCT assessment process, staff did not proceed with their assessment and did not complete one until 27 April, three days after ACCT procedures were initiated. A SO told the investigator that there were no circumstances in which an ACCT assessment would take place without a prisoner as it has to be conducted on a one-to-one basis. This is not in line with national policy. We consider that postponing the assessment delayed the process and that prison staff should have gone ahead with the assessment in Mr Murphy's absence.

70. Two SO's were the only members of staff to attend Mr Murphy's first case review. No healthcare staff attended, despite this being a mandatory requirement. One SO told us that once staff identify an issue at the first case review, the

appropriate member of staff is then asked to attend the following case review. We consider that a member of healthcare staff should have attended Mr Murphy's first case review to ensure that any immediate issues or concerns could be addressed as soon as possible.

71. A caremap must be completed at the first case review for all prisoners subject to ACCT monitoring. Caremaps should reflect prisoners' needs, the triggers of their distress, and must aim to address the issues identified at the assessment interview. The caremap should set time-bounded actions and aim to reduce the risk the prisoner presents to themselves. We are concerned that a caremap was not completed at Mr Murphy's first case review. A SO told us that he knew that he should have completed a caremap but could not remember if he did. We make the following recommendation:

The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including ensuring that:

- **staff conduct an initial assessment and first case review within 24 hours of starting ACCT procedures, whether or not the prisoner wishes to engage;**
- **healthcare staff always attend the first case review; and**
- **prison staff complete a caremap at the first case review.**

Emergency response

72. Brixton's local policy instructs staff to use a code blue to indicate when a prisoner is unconscious or having breathing difficulties. Calling an emergency medical code should automatically trigger the control room to call an ambulance, and for healthcare staff to attend with the appropriate emergency equipment.

73. When an officer found Mr Murphy unresponsive, he had to ask a prisoner to alert staff as he did not have radio. He told the investigator that there were no radios available when he started his shift and that this often happened at Brixton. While we recognise that another officer responded promptly and used an appropriate medical code, we are concerned that the lack of a radio caused an unnecessary delay of two minutes. We therefore consider that all operational members of staff should have access to a radio to allow emergency codes to be called without delay. We make the following recommendation:

The Governor should ensure that all operational staff have access to a working radio.

74. Two Officers and the officers who responded to the emergency code blue failed to start CPR. No one started CPR until a nurse arrived two minutes after an officer called the code blue. We consider that when prison staff find a prisoner unconscious and not breathing, they should start CPR immediately and not wait for healthcare staff to arrive. The clinical reviewer considered that as a considerable amount of time passed before Mr Murphy re-established a regular heartbeat, it was unlikely that the delay starting CPR had a material impact on the outcome for Mr Murphy, but it may be critical in other cases.

75. We are concerned that the healthcare staff who responded to the code blue did not bring an emergency medical bag or a defibrillator. They had to request this equipment, which meant it was not available for several minutes after the code blue had been called. PSI 03/2013 requires staff to bring all equipment relevant to the nature of the emergency.

76. A nurse told us that at HMP Brixton, the response nurse relies on other staff to collect the emergency equipment. She said that they needed to attend quickly to assess if an emergency response was required, as this was not always the case. While we recognise that a CM arrived with an emergency bag shorty after healthcare staff, a defibrillator was not brought in the first instance and the staff who went to collect a defibrillator, did not know where one was located. We therefore consider that all the appropriate emergency medical equipment should be taken every time an emergency code blue is called.

77. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including that:

- **prison staff administer basic life support as needed until healthcare staff arrive;**
- **healthcare staff take all appropriate medical equipment to medical emergencies; and**
- **all staff know whether defibrillators are located.**

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Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100
F I 020 7633 4141