

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr John Smith, a prisoner at HMP Brinsford, on 6 December 2020

**A report by the Prisons and Probation Ombudsman**

## Our Vision

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

## Our Values

We are:

**Impartial:** *we do not take sides*

**Respectful:** *we are considerate and courteous*

**Inclusive:** *we value diversity*

**Dedicated:** *we are determined and focused*

**Fair:** *we are honest and act with integrity*



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

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

Mr John Smith died in hospital of a head injury on 6 December 2020 while a prisoner at HMP/YOI Brinsford. Another prisoner had punched him in the back or side of his head the day before. Mr Smith was 26 years old. I offer my condolences to Mr Smith's family and friends.

The prisoner who punched Mr Smith was convicted of manslaughter and received a sentence of 37 months. He gave the court no reason for assaulting Mr Smith.

I am satisfied that staff could not have prevented Mr Smith's death.

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

**Elizabeth Moody**  
**Deputy Prisons and Probation Ombudsman**

**January 2022**

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# Summary

## Events

1. In May 2020, Mr John Smith was remanded into custody at HMP Birmingham, charged with breaching a community order and possession of a blade. He had been released from prison two days earlier. In July, he was sentenced to nearly two and a half years in prison and sent to HMP Stoke Heath. He was transferred to HMP Brinsford on 24 November 2020.
2. When he arrived at Brinsford, staff recorded that he had been under the care of the learning disability and mental health team at a previous prison because he had post-traumatic stress disorder and felt low. He was re-prescribed antidepressants and medication to treat his illicit substance misuse.
3. During his reception screen, staff started suicide and self-harm prevention procedures, known as ACCT, because Mr Smith had thoughts of suicide and self-harm. He was monitored under ACCT procedures throughout the 11 days he spent at Brinsford.
4. On 5 December, Prisoner X punched Mr Smith in the head in an apparently unprovoked attack. Mr Smith was taken to hospital, where doctors identified a bleed on the brain. His condition deteriorated overnight, and he died on 6 December.
5. Prisoner X was convicted of manslaughter and received a 37-month extended sentence.

## Findings

6. Mr Smith and Prisoner X lived in separate cells next to each other. There was no intelligence that the two prisoners did not get on. We are satisfied that staff could not reasonably have foreseen or prevented the incident on 5 December 2020.
7. Directly after the assault, the prisoner claimed that Mr Smith had made racist remarks to him. There is no other evidence to confirm whether this happened.
8. We do not know whether Mr Smith had taken drugs on 5 December as he was not tested.

## The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Brinsford, informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
10. The investigator obtained copies of relevant extracts from Mr Smith's prison and medical records.
11. NHS England commissioned a clinical reviewer to review Mr Smith's clinical care at the prison.
12. We suspended our investigation in December 2020 pending the outcome of criminal proceedings against another prisoner. Staffordshire Police agreed that the investigator could continue with parts of his investigation and gave permission for him to interview a number of staff. Staffordshire Police provided the investigator with their witness statements from staff and prisoners to assist with his investigation.
13. The investigator interviewed seven members of staff in February 2021, jointly with the clinical reviewer. The interviews were conducted by video and telephone because of the restrictions imposed due to the COVID-19 pandemic. We resumed our investigation in April 2021.
14. We informed HM Coroner for Staffordshire of the investigation. He gave us the cause of death. We have sent the Coroner a copy of this report.
15. The Ombudsman's family liaison officer contacted Mr Smith's mother to explain the investigation and to ask if she had any issues she wanted us to consider. She wanted to know all the circumstances leading to her son's death.
16. Mr Smith's mother received a copy of the initial report. She did not make any comments.
17. The initial report was shared with HM Prison and Probation Service (HMPPS). They identified no factual inaccuracies in the report.
18. The Coroner informed us that having reviewed the outcome of the criminal proceedings, an Inquest would not take place.

## Background Information

### HMP/YOI Brinsford

19. HMP/YOI Brinsford accommodates men on remand aged between 18 and 21 years, and men aged over 18 with sentences of less than four years. It offers a resettlement service for young adults and Category C adults who live in Staffordshire and the West Midlands. It has five residential wings and a healthcare centre.

### HM Inspectorate of Prisons (HMIP)

20. The most recent inspection of HMP/YOI Brinsford was in November 2017. Inspectors reported that, overall, levels of violence had not increased and Brinsford had managed to avoid the enormous increases in violence that had afflicted so much of the prison estate in recent years. However, they noted that self-harm had severely increased.
21. HMIP also carried out a Short Scrutiny Visit to Brinsford in June 2020, focussing on the care and basic rights of prisoners during the COVID-19 pandemic. They reported that prisoners were unlocked for no more than an hour a day in response to the pandemic. The prison remained stable, but both staff and prisoners were frustrated and concerned about the cumulative impact of the restricted regime. The number of recorded self-harm incidents had started to increase slightly. Processes were in place to support the most vulnerable and complex prisoners, and prisoners at risk of self-harm received daily welfare checks.

### 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 30 June 2020, the IMB reported that, similar to the previous year, staff were running a safe prison and, overall, despite a very restricted regime since March 2020 (due to COVID-19 restrictions), prisoners were treated fairly. The IMB noted that there continued to be ongoing incidents of violence, self-harm and substance misuse, although it noted that these were decreasing because of the COVID-19 restrictions which limited time out of cells.

### Previous deaths at HMP Brinsford

23. Mr Smith was the first prisoner to die at Brinsford since April 2018, and the first homicide at the prison.

### Prisoner X

24. Prisoner X had been at Brinsford since July 2019. In April 2020, he was sentenced to three years and seven months in prison for grievous bodily harm and having a weapon in a public place. It was his first time in prison. He was 20 years old.

25. His prison record shows that was involved in several incidents with other prisoners:

- July 2019 - a fight with another prisoner
- August 2019 – punched his cellmate to the back of the head
- September 2019 – kicked a door into another prisoner’s face causing an injury that required stitches
- October 2019 – threatened to stab his cellmate
- December 2019 – a fight with another prisoner
- June 2020 – assault on another prisoner
- October 2020 – assault on another prisoner using a can in a sock.

As a result, he had spent periods on the basic regime and in the segregation unit and was considered unsuitable to share a cell due to his risk to others.

## Key Events

26. On 27 March 2019, Mr John Smith was remanded to HMP Hewell for breaching a criminal behaviour order. It was his first time in prison. He was released from prison two months later, but the next day, he was found with a knife and remanded to HMP Birmingham.
27. Mr Smith's person escort record (PER) noted his history of substance misuse and self-harm. It noted that he was at risk of suicide and needed to be monitored. It also noted that he had learning difficulties and depression.
28. On 16 July, Mr Smith was sentenced to nearly two and a half years in custody, and on 23 July, he was transferred to HMP Stoke Heath. During his reception screen, staff noted that there were warnings in his record that he was violent and racist. In August, Mr Smith was moved to a standard wing after 14 days of isolation in his cell due to COVID-19 restrictions.
29. On the morning of 24 November, a learning disability nurse wrote to the healthcare team at Brinsford as Mr Smith was to be transferred there later that day. She said that the prison psychiatrist had seen Mr Smith on 23 November and prescribed sertraline (an antidepressant) as he felt low and had post-traumatic stress disorder (PTSD). She noted that Mr Smith was known to become tearful, had a history of self-harm and heard voices (but that this was not consistent with psychosis), and that he needed continued support and regular medication reviews. She also said that he was being supported by the substance misuse team and was on a methadone programme.
30. That afternoon, a nurse examined Mr Smith before his transfer. She recorded his prescribed methadone and sertraline.

### HMP Brinsford

31. Mr Smith arrived at Brinsford on the evening of 24 November. His PER warned that he could be violent, had committed a racially aggravated offence in the past and was under the care of the mental health team.
32. A nurse completed Mr Smith's reception health screen. Mr Smith told her that he had previously harmed himself, tied ligatures and had daily suicidal thoughts. He said that he had seen his best friend hang himself three years earlier and this had affected his mental health. He said he heard a mixture of voices, some good and some bad, and was struggling on his current medication. She told us that Mr Smith had been aggressive in Reception and was anxious about his transfer. She started suicide and self-harm prevention procedures, known as ACCT, and referred him to the mental health team.
33. Mr Smith asked for a single cell, and said he was more likely to harm himself if he had a cellmate. A Supervising Officer (SO) set hourly ACCT observations for Mr Smith until his ACCT assessment. Mr Smith was to remain on the induction wing for 14 days due to COVID-19 isolation restrictions.
34. On 25 November, a nurse completed Mr Smith's secondary health screen but noted no further health concerns. The SO completed Mr Smith's first ACCT

- review. He noted that it was not a full review as Mr Smith's ACCT assessment had not yet been completed. He recorded that Mr Smith appeared settled, and said he was happy in a single cell and understood that he would be moved after 14 days.
35. That day, a member of the substance misuse team, assessed Mr Smith and continued his methadone programme. He agreed to work with the clinical and psychosocial team to stay free from illicit drugs.
  36. On 26 November, an officer completed Mr Smith's ACCT assessment. He said that he had previously tried to hang himself and had harmed himself by cutting his arms about eight months earlier. He said that he had heard voices but his medication had improved how he felt and that he had no current thoughts of self-harm. The officer gave him some distraction packs and noted that the mental health and substance misuse teams should continue to support him.
  37. Afterwards, a SO conducted Mr Smith's first ACCT review. An officer attended and a nurse from the mental health team contributed by phone. Mr Smith talked about the trauma he had experienced and his attempts at taking his own life. Healthcare staff considered that the voices Mr Smith heard were associated with PTSD and related to the death of his friend, rather than mental health issues. Mr Smith said he wanted to work towards being drug-free on release. The SO agreed that Mr Smith should be assessed for the Development and Progression Unit (DPU, a calmer environment, designed for prisoners with a history of mental health issues and those struggling to cope and vulnerable). He set ACCT observations at five times during the day and hourly at night. The SO referred Mr Smith for a DPU assessment.
  38. Afterwards, a nurse from the mental health team assessed Mr Smith. She said that Mr Smith did not indicate that he was at immediate risk or that he felt vulnerable. She said that the move to Brinsford had destabilised him emotionally as he had felt settled at Stoke Heath. However, she said that he was happy that he had moved closer to his mother. She recommended that Mr Smith would benefit from living on the DPU as it was more supportive and he may be vulnerable from his peers who may take advantage of his lack of understanding and thought processing skills. A healthcare multidisciplinary team meeting was held on 27 November. It was agreed that Mr Smith would move to the DPU once his isolation period was completed and a space was available.
  39. On 29 November, Mr Smith's incentive and earned privileges (IEP) level was increased from standard to enhanced to reflect his continued good behaviour.
  40. On 2 December, a SO conducted an ACCT review with Mr Smith. The lead from the substance misuse team and a member of staff from the chaplaincy team attended. Mr Smith talked about his previous trauma and said that he was happy to be moved to the DPU. ACCT monitoring continued.
  41. The lead from the substance misuse team then saw Mr Smith for counselling. She told us that he talked to her about his trauma, his drug addiction and the impact this had had on his family. Mr Smith wanted to be free from drugs before he was released from prison and did not want to cause his family any more pain. He did not say anything about feeling at risk from any fellow prisoners. The lead

from the substance misuse team said Mr Smith left the session in a positive frame of mind.

#### Events of 4 December 2020

42. Mr Smith lived on G Wing, and Prisoner X lived in the adjacent cell. Staff had raised no concerns about either of them, or that they had any issues with each other.
43. On 4 December, staff noted that Mr Smith took part in exercise, collected his lunch and received the items he had ordered from the prison shop.
44. In his police statement, another prisoner who lived on the other side of Prisoner X's cell, said that he had heard banging noises at around 10.30pm. He initially thought the noise came from the landing below but also said it sounded like it was from their landing. He said it was normal for prisoners sometimes to hit the pipework in their cell to get the attention of others or to cause a disturbance.
45. When the banging stopped, another prisoner said he heard Mr Smith shouting, "Did you bang me, mate, you have woke me up [sic]". The prisoner said he heard Prisoner X respond to Mr Smith, "Why would I bang you up, bruv? [sic]" in a dismissive tone. It then went quiet after this. The prisoner said he thought that Mr Smith had possibly mistaken where the banging noise had come from and had asked Prisoner X if it was him and whether he was trying to get his attention.

#### Events of 5 December 2020

46. Due to COVID-19 restrictions, prisoners were offered daily exercise for 30 minutes. Prisoners on each wing landing were unlocked separately at different times. Staff unlocked prisoners on G2 (Mr Smith's landing) at around 2.15pm. Approximately 15 prisoners, including Mr Smith, took exercise in the prison yard. An officer was monitoring the prisoners but reported no concerns.
47. CCTV footage shows that prisoners returned to G2 landing after their exercise period at 2.55pm. Two officers were with the prisoners and talked to them. An officer spoke briefly to Mr Smith. He said Mr Smith told him that his mother was going to buy him some new clothes for Christmas and planned to bring them on her next visit to see him. The officer told Mr Smith that he would get him the forms he needed for this.
48. On G2 landing, prisoners were talking among themselves and a few stood outside their cell doors, waiting for prison officers to unlock their doors.
49. At just before 2.56pm, CCTV footage shows that Prisoner X walked up behind Mr Smith and punched him at the back or side of his head. Mr Smith did not know that Prisoner X was behind him. The force of the punch pushed Mr Smith's head into his cell door before he collapsed to the ground, possibly hitting his head again on the floor. Other prisoners slightly obscured the view when Mr Smith fell to the floor but he appeared motionless and unconscious.
50. Two officers were just yards away when the incident occurred, although neither saw what happened. In his police statement, an officer said that he heard a noise, a "thud" sound, from directly behind him. When he turned around, he saw

Mr Smith lying on the floor, on his back, with his head close to the officer's foot. Mr Smith's eyes were closed and he appeared unconscious. Prisoner X was standing on the other side of Mr Smith. In his police statement, an officer said he heard Prisoner X say, "That's what you get for being racist." The other officer said he heard Prisoner X say he had punched him because he had "been racist to him all night".

51. An officer quickly put Prisoner X into his cell. The officer rushed to Mr Smith's side. He was still unconscious and failed to respond to his name. An officer immediately pressed the general alarm button on the wall. The other officer radioed for healthcare assistance. The control room recorded that this occurred at 2.55pm. Both officers tried to put Mr Smith in the recovery position and get a response from him. Shortly afterwards, Mr Smith started to make mumbling noises, and made eye contact but did not speak.
52. Within 30 seconds, more staff responded to the alarm, which included four other officers. Two officers said in their police statements that when they arrived, Mr Smith appeared to be shaking, as if having a "fit" or "seizure". An officer said he saw a large amount of blood on the floor in the region of his head and so used his radio to call a code red emergency. The control room recorded that this occurred at 2.56pm. The spasm only lasted a short time and the officer helped put Mr Smith in the recovery position. The prison control room called an ambulance, recorded as occurring at 2.58pm.
53. CCTV shows that two nurses, equipped with medical emergency equipment, arrived to treat Mr Smith at 3.00pm. He was beginning to rouse when the nurses arrived.
54. A nurse told us that Mr Smith was sitting up against the wall when she arrived. He was quite vocal and said that he had fallen over and hit his head. She said that no prison staff had actually seen the incident and they did not know if and for how long he might have been unconscious. Mr Smith said that his head was "banging". In her police statement, a nurse said that Mr Smith was making a growling noise and seemed angry or frustrated. His first words were, "It really hurts." She said Mr Smith appeared vacant but not dazed or drowsy.
55. A nurse and her colleague completed a full range of medical observations and she was satisfied that Mr Smith showed no immediate neurological red flags. He had an egg-sized, hard lump at the back of his head, where there was also a small amount of blood. The nurses helped him stand up and he appeared to have no other injuries. He was coherent, talking and displayed no confusion. Based on her examination, the nurse decided to stand down the ambulance as it appeared that Mr Smith had had a 'slight' knock to the back of his head. The control room recorded that the ambulance was cancelled at 3.05pm.
56. The nurse said that the lighting on the wing was not good, and, as she had not seen the incident, she wanted to complete a fuller examination of Mr Smith's injury in a better lit area. She decided to do so in the healthcare unit. She intended to view the CCTV footage of the incident to understand what had happened.

57. The nurses encouraged Mr Smith to make the 10-minute walk to the healthcare unit. He continued speaking throughout. He said he did not want to leave the wing and appeared more concerned about the location of his vape. CCTV footage shows that Mr Smith initially struggled to walk, even with staff support. A nurse told us that a wheelchair was available, but that Mr Smith refused to use it. Staff therefore helped him move to the healthcare unit.
58. Once at the healthcare unit, Mr Smith told the nurses that he had recently taken 'mamba', an illicit psychoactive substance (PS). A nurse went to the nearby segregation unit to view the CCTV footage of the incident. Having done so, she realised that Mr Smith had received three blows to the head - from the punch, hitting the cell door and then hitting the floor and that he had apparently been knocked out for around a minute. She realised that the incident was more serious than initially thought and asked for an ambulance to be called again. A Custodial Manager (CM) radioed the control room to call an ambulance. This was done at 3.26pm.
59. The ambulance paramedics arrived at the healthcare unit at 3.44pm. One of the paramedics asked to see the CCTV footage of the incident, while the other examined Mr Smith. Within minutes, Mr Smith became drowsy, vomited and admitted again that he had taken PS shortly before he was assaulted. Due to the nature of the head injury and suspected illicit drug use, the paramedics decided to transfer Mr Smith to hospital for further assessment.
60. An officer was one of the escort staff who accompanied Mr Smith to hospital by ambulance. She told us that he was alert but did not say much, other than that his head was hurting.
61. At around 4.00pm, an officer and the SO escorted Prisoner X from his cell to the segregation unit. The SO asked Prisoner X why he had assaulted Mr Smith. Prisoner X said that someone had been banging on the windows or doors the night before and Mr Smith had thought that it was him. He said Mr Smith made a racist remark towards him, words to the effect of "It was you, you black bastard." Prisoner X said his response to Mr Smith was, "You can't be saying things like that in here. It will get you hurt."
62. At around 7.43pm, the hospital updated the prison on Mr Smith's condition. A brain scan had revealed that Mr Smith had sustained a subarachnoid bleed (a bleed on the brain) and was being transferred to the Queen Elizabeth Hospital in Birmingham, where surgical intervention was to be considered.
63. The prison tried to contact Mr Smith's mother, his next of kin, as soon as the hospital confirmed that Mr Smith had sustained a serious head injury. They made numerous attempts to contact her but no one answered and so they left messages for her to contact the prison. The prison also sought alternative contact details by checking Mr Smith's prison records.
64. At 3.29am on 6 December, prison escort staff provided an update on Mr Smith's condition. They reported that he had had a cardiac arrest when he arrived at hospital. He remained in a critical condition. Hospital staff continued to conduct further scans and to treat him.

65. Around 4.00am, the prison made contact with Mr Smith's mother and told her that Mr Smith was in hospital with a serious head injury. She was given the details of the hospital. She explained that she was away from home and would return as soon as possible. The hospital said that due to the COVID-19 pandemic restrictions, the family was unable to visit.
66. At around 5.00am, Mr Smith's condition deteriorated. At 6.30am, the hospital consultant told Brinsford that Mr Smith would not survive and they would soon need to switch off his life support. They confirmed that they had spoken to Mr Smith's mother and were waiting for her to arrive at the hospital. The consultant said that they would try to delay switching off Mr Smith's life support until his family arrived. At 12.10pm, the hospital confirmed that Mr Smith had died, with his family present.

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

67. An officer was appointed as the prison family liaison officer (FLO) and spoke to Mr Smith's mother at around 1.15pm on 6 December. Mr Smith's mother arranged to meet the FLO the next day.
68. The Governor, the FLO and a member of the chaplaincy team visited the family on 7 December, to provide further information about Mr Smith and offer their support. The prison contributed towards the cost of funeral arrangements in line with national policy.

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

69. The prison posted notices informing other prisoners of Mr Smith's death and offering support. Staff reviewed all prisoners considered at risk of suicide and self-harm in case they had been adversely affected by Mr Smith's death.
70. After Mr Smith's death, a senior manager saw Prisoner X in the segregation unit and told him Mr Smith had died. Prisoner X was placed on ACCT monitoring the following day.

### **Post-mortem report**

71. The Coroner established that Mr Smith had died from a head injury.

### **Additional information following Mr Smith's death**

72. On 15 December, Prisoner X was charged with manslaughter. He was convicted and on 21 April 2021, he received an extended sentence of 37 months. During the trial, Prisoner X did not say that he punched Mr Smith because of a racist comment. The judge concluded that there was no evidence that Mr Smith had been racist towards Prisoner X in this instance.

# Findings

## Mr Smith's risks and safety

73. Mr Smith had only been at Brinsford for 11 days when he was assaulted. He was monitored by ACCT procedures throughout his short time at Brinsford. Although he had been assessed as potentially vulnerable, and was to be transferred to the DPU once he had completed his 14-day COVID-19 isolation period on the induction wing, neither staff nor Mr Smith had raised concerns that he was at any specific risk from other prisoners. We are satisfied that there was nothing to indicate that his move to the DPU should have been expedited.
74. Although Prisoner X had a history of fights with and assaults on other prisoners, there was nothing to suggest that he and Mr Smith did not get on or that he posed a specific risk to Mr Smith. Prisoner X's motivation for punching Mr Smith is not known, and there is no evidence to say whether it was racially motivated. It appears that Prisoner X wanted to hurt Mr Smith and had not intended to kill him.
75. We are satisfied that prison staff could not reasonably have predicted or prevented Prisoner X's actions or Mr Smith's death.

## Clinical care

76. The clinical reviewer was satisfied that the care that Mr Smith received in prison, including the emergency response, was equivalent to that which he could have expected in the community

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