

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr John Brundle, a prisoner at HMP Elmley, on 22 January 2021

**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.

Our 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 Brundle died on 22 January 2021, having been found hanging in his cell in HMP Elmley. Mr Brundle was 50 years old. I offer my condolences to Mr Brundle's family and friends.

Mr Brundle was only in Elmley for two days. We are concerned that he was not subject to suicide and self-harm monitoring, despite a recent attempted overdose and other risk factors. We are also concerned that there is little evidence of meaningful interaction between Mr Brundle and prison staff during his brief time at the prison.

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

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

**February 2022**

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# Summary

## Events

1. Mr John Brundle was sentenced to 56 days imprisonment on 20 January 2021 and taken to HMP Elmley. He had been there and in other prisons before. He had a history of self-harm, alcohol misuse and mental health problems.
2. Mr Brundle appeared calm during his reception screen and told staff that he had no thoughts of self-harm, although he said he had tried to overdose eight days earlier following a family argument. He was referred to the doctor and the substance misuse team. Staff assessed that Mr Brundle was not at risk of suicide or self-harm, so did not start monitoring and support measure (known as ACCT).
3. Mr Brundle's mental health history was noted but he was not referred for a mental health assessment. He was put onto an alcohol detoxification plan and was allocated a single cell.
4. The prisoner in the neighbouring cell said that Mr Brundle told him that his cell was dirty and that he did not have a kettle or a working television and that Mr Brundle seemed "really depressed" the following day. The prisoner said that Mr Brundle asked to speak to a Listener (prisoners trained by the Samaritans to provide peer support) on the evening of 21 January, but that the prison officer he spoke to suggested that Mr Brundle call the Samaritans on his in-cell telephone instead as the Listener's scheme had been suspended at Elmley during the pandemic. He did not do so.
5. The next morning, 22 January, a substance misuse nurse routinely assessed Mr Brundle and he continued the detoxification programme. At lunchtime, Mr Brundle pressed his cell bell and asked for some clothes. A prison officer told him to ask later that afternoon.
6. At 2.43pm, a prison officer escorted a nurse to give Mr Brundle his medication. They could not get into the cell because Mr Brundle had barricaded the door. They saw that he was hanging. They called an emergency medical code, got into the cell and tried to resuscitate Mr Brundle. They continued until joined by colleagues, and then by ambulance staff. At 3.25pm, it was agreed that Mr Brundle had died.

## Findings

### Assessment of risk

7. No staff who saw Mr Brundle during his two days at the prison considered that he was a risk to himself. This is despite a history of self-harm, a recent attempted overdose just eight days before coming to prison, and a request to speak to a Listener the evening before he died. We consider that staff relied too heavily on Mr Brundle's presentation and did not sufficiently consider his risk factors to inform their assessment of his risk.

## Meaningful interaction with Mr Brundle

8. Mr Brundle had to isolate because of COVID-19 procedures. There is no evidence that staff had any meaningful contact with him that might have enabled them to identify or address his concerns.

## Mr Brundle's cell

9. We are concerned that Mr Brundle's cell did not have a working kettle or television when he was moved into it and that he complained it was dirty.
10. We are also concerned that although the prison told us that the cell would have been deep cleaned after the previous occupant contracted COVID-19, there is no evidence that this was done.

## Clinical care

11. The clinical reviewer concluded that the care given to Mr Brundle was equivalent to that which he could have expected in the community. His alcohol detoxification was well managed.
12. The clinical reviewer was, however, concerned that Mr Brundle was not referred for a mental health assessment, despite his history of self-harm and his admission to a psychiatric hospital in 2019. This was contrary to national clinical guidelines.

## Recommendations

- The Governor and Head of Healthcare should ensure that prison and healthcare staff understand that they should consider a prisoner's risk factors for suicide and self-harm when assessing risk and should not rely solely on what the prisoner says about his intentions or how he presents.
- The Governor should ensure that staff:
  - have regular meaningful interaction with the prisoners in their care; and
  - record important interactions and conversations in NOMIS and the wing observation book.
- The Governor should ensure that:
  - cells are always properly equipped and cleaned before prisoners are moved into them; and
  - a record is kept when a cell is deep cleaned for any reason.
- The Head of Healthcare should ensure that prisoners who have a history of self-harm and/or have previously been admitted to a psychiatric hospital are referred for a mental health assessment in reception, in line with NICE guidelines.

## The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Elmley informing them of the investigation and asking anyone with relevant information to contact him.
14. The investigator obtained copies of relevant extracts from Mr Brundle's prison and medical records.
15. The investigator interviewed two members of staff and a prisoner at Elmley in January and June 2021. NHS England commissioned a clinical reviewer to review Mr Brundle's clinical care at the prison. The interviews were completed by telephone because of the COVID-19 restrictions in place.
16. We informed HM Coroner for Mid Kent and Medway of the investigation. She gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
17. One of the Ombudsman's family liaison officers contacted Mr Brundle's sister, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not raise any specific questions.

# Background Information

## HMP Elmley

18. HMP Elmley holds up to 1,252 men, remanded and sentenced, in six houseblocks with a mixture of single, double and triple cells. Integrated Care 24 Ltd provides 24-hour primary healthcare services, with input from Minster Medical Group. Oxleas NHS Foundation Trust provides mental health services.

## HM Inspectorate of Prisons

19. The most recent inspection of HMP Elmley was a short scrutiny visit in April 2020. Inspectors reported that considerable efforts had been made to keep prisoners occupied while COVID-19 restrictions meant more time in their cells, with a full-time activities team having been established. Efforts had been made to promote safer environments with rigorous cleaning. The in-cell phone system allowed staff to call prisoners to check on their wellbeing.
20. The last full inspection at Elmley was in April and May 2019. Inspectors reported that reception and induction procedures had improved since the previous inspection. Support for prisoners in their early days was reasonably good. The inspectors found that newly arrived prisoners were referred for appropriate mental health and substance misuse services.

## Independent Monitoring Board

21. 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 October 2020, the IMB noted that usage of ACCT rose during the year.

## Previous deaths at HMP Elmley

22. Mr Brundle was the tenth Elmley prisoner to die since the beginning of 2019. Eight of the previous deaths were due to natural causes, and one was apparently drug-related. There are no significant similarities between our finding in this investigation and our findings in the previous investigations.

## Assessment, Care in Custody and Teamwork (ACCT)

23. 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.
24. 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.

25. 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

### Wednesday 20 January 2021

26. On 20 January 2021, Mr John Brundle was convicted of causing damage to property and sentenced to 56 days imprisonment. He was taken to HMP Elmley. There were no alerts or warnings on the Person Escort Record (PER) that arrived with Mr Brundle from court.
27. Mr Brundle had been in prison before, including at Elmley. He had a long history of alcohol misuse. He also had a history of self-harm, both in prison and in the community. He had previously been managed under Prison Service procedures to monitor and support those at risk of self-harm (known as ACCT). In 2019, he had been sectioned under the Mental Health Act and detained in a secure mental health unit after he stabbed himself following an argument with a family member.
28. Nurse A carried out Mr Brundle's first reception health screen. He noted that Mr Brundle had had a history of mental health problems. Mr Brundle told the nurse that he did not have any thoughts of suicide or self-harm, but that he had tried to overdose eight days before coming to prison following a family argument. He told the nurse that he had been drinking. The nurse noted that Mr Brundle had been prescribed mirtazapine (for depression) in the community and that he had a colostomy (where the bowel is diverted through an opening in the stomach and a bag is used to contain bowel movements). He also noted that Mr Brundle was subject to ACCT procedures, although this was not the case.
29. Nurse A described Mr Brundle as "agreeable to his current situation" and noted he was open and alert during their conversation. He noted that Mr Brundle was alcohol dependent and that he had been admitted to a psychiatric hospital in 2019 following a previous episode of self-harm. He did not think that Mr Brundle was at risk of suicide or self-harm or in need of mental health assessment, despite his recent overdose. He recorded that he told Mr Brundle how to access mental health care if he wanted, though he did not refer him for a mental health assessment. He referred Mr Brundle to a nurse prescriber to assess his medication and to the doctor for a substance misuse assessment. (The nurse subsequently left Elmley and so we were not able to interview him.)
30. Dr A, a prison GP, assessed Mr Brundle shortly afterwards. He noted that Mr Brundle had difficulty remembering some things that he was asked, and was unsteady on his feet, and that he had a long history of alcohol dependence. The doctor put in place a detoxification plan, including medication to aid withdrawal and psychosocial support from the Forward Trust (a charity that works with prisoners with substance misuse problems), and referred him to the substance misuse team.
31. Nurse B, a mental health nurse, was the nurse prescriber on duty in reception, and he saw Mr Brundle to assess his medication. The nurse noted Mr Brundle's medical history, including his use of a colostomy bag. He described Mr Brundle as "calm and lucid" and recorded that he had no thoughts of self-harm. In interview, the nurse said that he had no concerns that would merit starting ACCT procedures or that he needed urgent intervention for his mental health.

32. Mr Brundle then saw Nurse C, a substance misuse nurse. He told the nurse that he was relieved to be in prison as he had been finding life stressful and it provided an opportunity to stop drinking. The nurse confirmed the plan to manage his alcohol detoxification: Mr Brundle was to be observed at least twice during the night for symptoms of alcohol withdrawal and assessed daily.
33. Officer A saw Mr Brundle for his first night interview. She described him as “relaxed and happy to talk”. She assessed Mr Brundle’s risk of harm to himself, which included asking him about it. He said that he had no thoughts of harming himself, and the officer did not consider that he was a risk to himself. She noted on his Early Days in Custody sheet that he may suffer from mental health problems. Because of this and indications of vulnerability in previous sentences, she assessed Mr Brundle as at high risk of sharing a cell and he was allocated a single, standard cell in the detoxification unit. He was not issued with a PIN phone number (which would have enabled him to ring family and friends) because of the nature of his offence which meant his contact numbers would need special clearance. He would need to spend 10 days in precautionary isolation due to the COVID-19 pandemic.
34. Mr Brundle and the prisoner in the next cell knew each other from previous sentences and spoke to each other through the wall and window. The prisoner said in interview that Mr Brundle was irritated that his cell was not clean and that he did not have a kettle or a working television aerial. The prisoner said he told Mr Brundle that the previous occupant of the cell had tested positive for COVID-19. Mr Brundle was upset so the prisoner said he suggested that he ask staff for a kettle and an aerial. (There is no note on Mr Brundle’s record or in the wing observation book that he did so, although the prisoner said that the officers gave him two further televisions, neither of which worked.) He said that he made a makeshift aerial and passed it to Mr Brundle, which allowed him to get some reception on his television and that Mr Brundle seemed to calm down and said he felt better. He said that Mr Brundle did not seem particularly down or depressed that evening.

#### Thursday 21 January

35. On Thursday 21 January, Nurse B assessed Mr Brundle for symptoms of alcohol withdrawal. He recorded that Mr Brundle had moderate symptoms of withdrawal and that he should continue with the detoxification plan.
36. Mr Brundle then saw someone from the healthcare team about his colostomy. They noted a swelling in his abdomen which could be a hernia and referred him to the doctor. Mr Brundle told the nurse that he was unhappy with his cell, which he said was dirty and smelled. They recorded that Mr Brundle was “unkempt”, “angry” and “uncooperative” during their conversation.
37. That afternoon, a member of the chaplaincy saw Mr Brundle for an induction meeting.
38. The prisoner in the next cell to Mr Brundle said Mr Brundle seemed “really depressed” that evening. He said Mr Brundle told him he was “not feeling good”, and that he was worried about catching COVID-19 from the cell’s previous occupant and wanted a cleaner cell. He said he heard Mr Brundle ask an officer

if he could speak to a Listener (prisoners trained by the Samaritans to provide peer support). He said the officer told Mr Brundle that the Listeners scheme had been suspended because of the COVID-19 restrictions, but that the officer “did not fob him off” as he came back and told him he could call the Samaritans on his in-cell telephone. Records show that Mr Brundle did not do so.

### **Friday 22 January**

39. On the morning of 22 January, Nurse D, a substance misuse nurse, checked Mr Brundle and once again recorded that he should continue on the current treatment programme.
40. The prison who was in the next cell to Mr Brundle said that Mr Brundle was quiet in the morning but that they spoke briefly and Mr Brundle said he was “alright”. He said that by this time, the officers had sorted out Mr Brundle’s television and kettle.
41. At 1.02pm, Mr Brundle pressed his cell bell and Officer B answered. The officer said in his statement that Mr Brundle was watching television and asked if he could have some more prison clothing. He said that the prison was in patrol state (prisoners locked in cells for lunch) so he could not get him any clothes at that time, but that he should ask again that afternoon. He said he told Mr Brundle that he would let colleagues know that he had asked and that Mr Brundle thanked him. CCTV footage showed that they appeared to speak for about 30 seconds. The prisoner in the neighbouring cell said that, shortly after this, he was working out in his cell, making quite a noise, and that he thought he heard a noise from Mr Brundle’s cell. He said he called to him, but Mr Brundle did not reply. He said he was not concerned about Mr Brundle and thought no more about it.
42. Officer C was escorting Nurse E, a substance misuse nurse, to distribute medication that afternoon. At 2.41pm they went to Mr Brundle’s cell, but the nurse was not sure it was the correct cell so he went to check his records and returned two minutes later. The officer tried to open the door but was unable to do so. He looked through the observation panel and saw Mr Brundle hanging from the window by a ligature made from a bed sheet.
43. Officer C used his radio to call an emergency ‘code red’ (indicating a medical emergency involving blood or burns). This prompted the prison’s control centre to request an ambulance. Mr Brundle had piled furniture against the door to form a barricade. The officer and colleagues who had responded to the emergency call forced entry and cut the ligature. They lowered Mr Brundle to the floor and began cardiopulmonary resuscitation (CPR). Other staff, including medical staff, arrived and they continued to try to resuscitate Mr Brundle. They carried on until ambulance staff arrived and took over. At 3.25pm, it was agreed that Mr Brundle had died.
44. Mr Brundle had been routinely tested for COVID-19 when he arrived at Elmley. A note on his medical record dated 23 January showed that the result was positive.

### **Contact with Mr Brundle’s family**

45. The prison's family liaison officer contacted Mr Brundle's sister to inform her of her brother's death. In line with Prison Service guidance, Elmley offered a contribution to the costs of Mr Brundle's funeral.

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

46. After Mr Brundle's death the Deputy Governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
47. The prison posted notices informing other prisoners of Mr Brundle'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 Brundle's death. The prisoner in the next cell to Mr Brundle said he received good support.

### **Post-mortem report**

48. The post-mortem report showed that Mr Brundle died as a result of suspension (hanging). Toxicology tests showed small amounts of Mr Brundle's prescribed medication, but no other drugs or alcohol in his system.

# Findings

## Assessment of risk

49. Mr Brundle had only been at Elmley for 48 hours when he was found hanging. We have therefore considered whether his risk of self-harm was appropriately assessed and managed.
50. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, which sets out the Prison Service's framework for delivering safer custody procedures, lists a number of risk factors and potential triggers for suicide and self-harm. Mr Brundle was only serving a short sentence but was detoxing from alcohol, had a history of mental ill health and serious self-harm and had recently attempted an overdose.
51. Mr Brundle told Nurse A, who carried out his reception health screen, that he had taken an overdose eight days earlier, that he had been sectioned under the Mental Health Act following a previous self-harm incident, that he was alcohol dependent, and that he was prescribed medication for depression. These are all risk factors for suicide and self-harm. We are concerned that the nurse did not consider this sufficient to begin ACCT procedures and that he did not pass the important information about Mr Brundle's recent overdose to prison staff, who might have managed Mr Brundle differently if they had known. We are also concerned that the nurse incorrectly recorded that Mr Brundle was being managed under ACCT procedures.
52. Nurse A noted that Mr Brundle did not display any anxiety, and both the nurses and the doctor who saw him in reception noted that Mr Brundle said he had no thoughts of harming himself or suicide. However, as we have said repeatedly in individual investigation reports, thematic reports and annual reports, too often staff make decisions about risk based on their perceptions of a prisoner's presentation and statements from the prisoner that they do not have any thoughts or intentions of suicide or self-harm. It is important that staff also consider the prisoner's risk factors when assessing the risk of harm. In this case we do not consider that staff adequately explored Mr Brundle's recent self-harm or other risk factors to inform their assessment.
53. Elmley said that prison staff are aware of risks and triggers through training. However, the Offender Management Unit checklist for new reception prisoners does not contain any reference to assessing risk of self-harm. We cannot say how far Mr Brundle's vulnerability was assessed by non-medical staff. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that healthcare and prison staff understand that they should consider a prisoner's risk factors for suicide and self-harm and should not rely solely on what the prisoner says about his intentions or how he presents.**

## Listeners

54. The Listeners scheme was suspended at Elmley on 9 October 2020 as part of the response to the COVID-19 pandemic. The number of trained Listeners in

Elmley had dropped to five prisoners (pre-pandemic this would have normally been 20-25) and the Samaritans could not go into the prison to train new volunteers. Because of movement restrictions, those Listeners who remained were not allowed to move around the prison and or have face-to-face contact with other prisoners.

55. Notices had been issued to staff and prisoners explaining the suspension. The notices told prisoners that they could use their in-cell telephones to call the Samaritans, or that they could use the Listeners' suites to do so. Staff were to ensure that in-cell telephones were working. These restrictions remained in place until May 2021. Although it is very unfortunate that Mr Brundle could not speak to a Listener on 21 January, we accept that it was reasonable to suspend the Listener scheme in the circumstances.
56. However, we are concerned that the officer who spoke to Mr Brundle did not record in his prison record that he had asked for a Listener. There is no evidence that he that he offered any further support or asked Mr Brundle what was wrong, or that he passed this information on to his colleagues or that he considered whether he should open an ACCT.

### **Meaningful interaction with Mr Brundle**

57. As a newly received prisoner, Mr Brundle was restricted in his contact with others in line with COVID-19 isolation procedures and spent around 23 hours a day locked in his cell. In these circumstances we would have expected that staff would have had meaningful contact with new prisoners to offer them support and to check on their mood and wellbeing. We are, therefore, concerned that, other than the first night interview and an induction visit from a member of the chaplaincy team on 21 January, there is no evidence that staff had any interaction with Mr Brundle.
58. We make the following recommendation:

#### **The Governor should ensure that staff:**

- **have regular meaningful interaction with the prisoners in their care; and**
- **record important interactions and conversations in NOMIS and the wing observation book.**

### **Mr Brundle's cell**

59. We are concerned that, although the prisoner in the next cell to Mr Brundle and a nurse said that Mr Brundle was upset that he did not have a working television or a kettle and that his cell was dirty, there is no reference to this in his prison record or the wing observation book. We consider that it is especially important that cells are properly equipped when prisoners are spending so long in them. In addition, it is unacceptable for prisoners to be placed in dirty cells at any time, but especially so during the COVID-19 pandemic when hygiene is a key element in controlling the spread of the virus.

60. The prisoner in the next cell to Mr Brundle also said that he and other prisoners told Mr Brundle that the previous occupant of his cell had been moved out after contracting COVID-19. The prison has confirmed that this was the case. This is unlikely to have helped Mr Brundle's sense of wellbeing, although we appreciate that cells have to be re-used.
61. However, if the previous occupant had been positive for COVID-19, it would have been even more essential to ensure that the cell was properly cleaned before Mr Brundle was moved into it. The prison told us that the cell would have been deep cleaned after the previous occupant moved out, but there is no evidence that this was done. We are very concerned that the fact that Mr Brundle complained that his cell was dirty, suggests that it had not in fact been deep cleaned.
62. We recommend:

**The Governor should ensure that:**

- **cells are always properly equipped and cleaned before prisoners are moved into them; and**
- **a record is kept when a cell is deep cleaned for any reason.**

**Clinical care**

63. The clinical reviewer noted that Mr Brundle's alcohol detoxification was well managed. He considered that the care given to Mr Brundle was equivalent to that which he could have expected in the community.
64. However, he was concerned that the reception nurse did not refer Mr Brundle for a mental health assessment when he first arrived at the prison. Mr Brundle had been admitted to a psychiatric hospital in 2019 and had a history of self-harm. NICE guidelines require that prisoners who have spent time in a psychiatric hospital or have self-harmed in the past are referred for a mental health assessment. There is nothing to suggest that Mr Brundle needed an urgent referral, so it is unlikely that he would have been assessed before he died. Nevertheless, we make the following recommendation:

**The Head of Healthcare should ensure that prisoners who have a history of self-harm and/or have previously been admitted to a psychiatric hospital are referred for a mental health assessment in reception, in line with NICE guidelines.**

**Emergency response**

65. Prison Service Instruction 03/2013 requires governors to have a two-code medical emergency response system based on the instruction. As is usual, Elmley use code blue to indicate an emergency when a prisoner is unconscious, or having breathing difficulties, and code red when a prisoner is bleeding. Calling an emergency code should automatically trigger the control room to call an ambulance and tells healthcare staff what equipment to take to the emergency.
66. When Officer C saw Mr Brundle hanging, he rightly called an emergency code, but used the incorrect code red rather than blue (indicating a medical emergency involving breathing difficulties or a collapse). The officer said in interview he was

aware of the correct codes and simply made a mistake in the heat of the moment. We are satisfied that this was a genuine mistake, which did not delay emergency medical care in this case and do not make a recommendation.



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