

**Prisons &
Probation**

Ombudsman
Independent Investigations

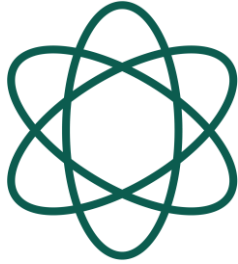
Independent investigation into the death of Mr Kazaar McKenzie, a prisoner at HMP Brixton, on 5 June 2019

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

OGL

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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.

Our investigation in this case was suspended while the police made enquiries, and again while we waited for the results of post-mortem toxicology tests and the prison's internal investigation.

Mr Kazaar McKenzie was found hanged in his cell at HMP Brixton on 5 June 2019. He was 29 years old. I offer my condolences to Mr McKenzie's family and friends.

Mr McKenzie had a history of substance misuse, mental health issues and self-harm. In December 2018, he had been managed under Prison Service procedures to support those at risk of harming themselves (known as ACCT) at HMP Wandsworth after self-harming and saying he wanted to die.

On 4 June, Mr McKenzie told a prison officer that he had thoughts of taking his own life. Staff appropriately started ACCT procedures. However, I am concerned that Mr McKenzie's risk was not properly assessed and that his risk was not reviewed after he was restrained, barricaded his cell and refused food on the day of his death (all factors that may have indicated his risk had increased).

I am also concerned that although Mr McKenzie had told a member of healthcare staff that he felt victimised by staff some months before he died, she did not report this allegation and it was not, therefore, investigated. There is insufficient evidence for me to say whether this allegation was founded in fact.

There was a five-minute delay in using an emergency code to call an ambulance when Mr McKenzie was found hanging. Although this does not appear to have affected the outcome for Mr McKenzie, it could make a critical difference in other medical emergencies.

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

December 2020

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Summary

Events

1. Mr Kazaar McKenzie was convicted of drug offences in August 2018 and taken to HMP Wandsworth. He had been in prison before and had a history of substance misuse, mental health issues and self-harm.
2. In December 2018, Mr McKenzie harmed himself and was managed under ACCT procedures. He said he was struggling with guilt about something he had done in the past. He was referred to a psychiatrist and prescribed medication.
3. Mr McKenzie moved to HMP Brixton on 30 January 2019. He was referred to the Health and Wellbeing team for counselling.
4. On the morning of 4 June, Mr McKenzie's cellmate was released from prison. Mr McKenzie told a prison officer that he was distressed about something he had done in the past and was struggling with guilt. Staff started ACCT procedures and placed him on hourly observations but did not assess his risk before he died. Throughout the day, Mr McKenzie blocked his observation panel, and put furniture behind his door. He did not want to speak to officers or healthcare staff.
5. On 5 June, Mr McKenzie objected to sharing his cell with another prisoner. Officers eventually restrained him to move him back into his cell. Mr McKenzie repeatedly blocked his observation panel during the afternoon and refused food, but assured staff he was okay. At about 5.40pm, he was seen by a nurse who noted that he was tearful.
6. At 7.14pm, during a routine evening check, officers noticed Mr McKenzie had blocked his observation panel again, but on this occasion, he did not respond to them. Officers opened his door and found Mr McKenzie hanging. They moved him to the landing and attempted resuscitation until paramedics arrived and took over. At 9.06pm, paramedics pronounced that Mr McKenzie had died.

Findings

Management of Mr McKenzie's risk of suicide or self-harm

7. Officers appropriately identified Mr McKenzie's risk of suicide or self-harm on 4 June and opened an ACCT. However, we are concerned that they failed to assess that risk and did not notify healthcare staff when the ACCT was opened, and so missed a crucial opportunity to put effective support measures in place.
8. We are also concerned that staff did not review Mr McKenzie's risk of suicide or self-harm when he was subject to a use of force, refused food and barricaded his cell on 5 June (all factors that may have increased his risk).
9. Following Brixton's internal investigation into Mr McKenzie's death, the supervising officer who opened the ACCT faced disciplinary proceedings for failing to ensure that an ACCT assessment took place.

Bullying

10. On 4 March, Mr McKenzie told a member of healthcare staff that he felt victimised by staff. We are concerned that this allegation was never reported or investigated. There is no evidence that Mr McKenzie spoke to any other member of staff about this before he died, although he did repeat this concern to a friend. There is insufficient evidence for us to determine whether staff were bullying Mr McKenzie or not.

Drug issues

11. Mr McKenzie had a history of drug use and post-mortem tests found traces of illicit substances in his system when he died. There is no intelligence to suggest that Mr McKenzie was in debt or being bullied as a result of his drug use.

Clinical care

12. The clinical reviewer concluded that while much of Mr McKenzie's healthcare was equivalent to that which he could have expected in the community, he could have benefitted from a formal assessment of his mental state following his behaviour on 4 June.
13. We are concerned that a nurse did not share her concerns about Mr McKenzie's state of mind with prison or healthcare staff on 4 and 5 June. We understand that the Nursing and Midwifery Council is currently considering her fitness to practice.

Emergency response

14. We are concerned that there was up to a five-minute delay radioing an emergency medical code when staff found Mr McKenzie hanging, which resulted in a delay calling an ambulance. Although this does not appear to have affected the outcome for Mr McKenzie, since CPR was started promptly, it could make a critical difference in future medical emergencies.

Recommendations

- The Governor and the Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, in particular, that:
 - all staff know they should open an ACCT if they are concerned that a prisoner may be at risk;
 - ACCT assessments are completed promptly, at least within the required timescales;
 - healthcare staff are notified when a prisoner is made subject to ACCT monitoring;
 - staff review the prisoner's risk following events or behaviour that suggest risk may have increased.

- The Governor and the Head of Healthcare should ensure that prisoners are examined by a doctor or nurse in line with PSO 1600 after any use of force.
- The Governor and Head of Healthcare should ensure that staff are aware of how to report allegations of bullying by staff and that all such allegations are investigated.
- The Governor should remind staff of the importance of using a medical emergency code as soon as possible in an emergency, and the potential consequences of not doing so.

The Investigation Process

15. 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.
16. The investigator visited Brixton on 10 June 2019. He obtained copies of relevant extracts from Mr McKenzie's prison and medical records. Interviews could not take place until the police investigation had been completed.
17. NHS England commissioned a clinical reviewer of Nina Murphy Associates to review Mr McKenzie's clinical care at the prison.
18. In October 2019, an investigator interviewed seven members of staff at Brixton, and two former members of staff, and he and the clinical reviewer jointly interviewed a former member of healthcare staff at the PPO's offices. The clinical reviewer also interviewed two members of healthcare staff by telephone in November and December, and met the Head and Deputy Head of Healthcare at the prison in November.
19. We informed HM Coroner for Inner South London of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
20. One of the Ombudsman's family liaison officers contacted Mr McKenzie's mother, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Solicitors acting for Mr McKenzie's family raised several issues, including:
 - Family and friends had been in touch with Mr McKenzie by text message shortly before he died and he was fine, and the family do not therefore believe that he took his own life.
 - Mr McKenzie told a friend on 30 May 2019 that he was being bullied by prison officers.
 - Mr McKenzie was upset when his cellmate left a few days before he died and the family do not understand why he was not given another cellmate.
 - How was it possible for Mr McKenzie to hang himself when the wing office was immediately opposite his cell?
21. We have tried to address the family's concerns in this report and in the clinical review, and through separate correspondence.

Background Information

HMP Brixton

22. 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. Healthcare services are available in the prison until 6.30pm on weekdays.

HM Inspectorate of Prisons

23. The most recent inspection of HMP Brixton was conducted in March 2019. Inspectors reported that since the previous poor report there had been a transformation in some key areas of the prison's performance. There had been particular improvement in how the prison addressed illicit drugs, and in the management of ACCT procedures.

Independent Monitoring Board

24. 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 2019, the IMB reported that although there had been improvements, the operation of ACCT processes was imperfect.

Previous deaths at HMP Brixton

25. Mr McKenzie was the third prisoner to die at HMP Brixton since June 2017. One of the previous deaths was drug-related and one was due to natural causes. There have been two deaths since, both from natural causes.
26. In a report into a death at Brixton in May 2018 we found deficiencies in managing ACCT procedures, and a delay in using an emergency code. We make similar findings in this investigation. (The prison had not seen our report into the earlier death before Mr McKenzie died.)

Assessment, Care in Custody and Teamwork

27. 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.
28. 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.
29. 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, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*.

Key Events

30. On 29 August 2018, Mr Kazaar McKenzie was convicted of drug offences and sentenced to 22 months imprisonment. He was taken to HMP Wandsworth.

2014-2015

31. Mr McKenzie had been in prison before in 2014-2015, and during this time he had self-harmed and was subject to ACCT monitoring at times. He revealed at least three suicide attempts which had taken place outside the prison. He had two long periods of direct one-to-one support from psychologists to help him to manage his emotions. He found this useful but it was sometimes too difficult for him to put into operation the techniques he had learned and he reverted to more harmful behaviours. He was seen and assessed by the mental health team who found no sign of serious and enduring mental illness. He was diagnosed with depression and treated appropriately with antidepressants and talking therapy.
32. Mr McKenzie found sharing a cell irritating and unacceptable at times during this period. He asked the mental health team to support his request for a single cell, but they found no clinical reason for doing so. He also had times when he preferred not to socialise and he sought help when this became a problem for him.
33. In May 2015, while at HMP Thameside, he referred to issues in the past which might have caused him distress, but he did not wish to explore whatever these issues were. Triggers for his distress appeared to be thinking about some of his previous actions and concerns about lack of contact with his daughter.
34. He was released from prison in November 2015.

HMP Wandsworth: July 2018 to January 2019

35. When Mr McKenzie arrived at Wandsworth on 30 July 2018, he refused to allow healthcare staff to access his community GP records. He said he had not used drugs in the last month and had no thoughts of suicide or self-harm. (He later disclosed that he had used cocaine and cannabis a few days before entering prison.)
36. In September and October, he was seen by a counsellor for help with anger management and emotional turbulence.
37. In November, he told a prison GP he was anxious, low in mood and not sleeping well. He was prescribed an antidepressant.
38. On 3 December, Mr McKenzie was found with “many ligatures and a noose attached to his bed” and superficial cuts to his wrists. He said he had had enough and might try to take his life at any time. He also said that he was hearing voices telling him to kill himself. He was referred for an urgent psychiatric assessment and was managed under ACCT (initially under constant supervision).
39. He told a nurse and the duty governor that he was troubled by events in his past when he had sexually abused a family member and that he was planning to

apologise. He thought other prisoners might know about this and that they were talking about him, and he could hear his own thoughts in his head.

40. The next day, he saw the prison psychiatrist, who noted that Mr McKenzie appeared to have had a brief psychotic episode and prescribed olanzapine (an anti-psychotic drug) and mirtazapine (an antidepressant).
41. The ACCT remained in place until 11 December. On 27 December, the prison doctor reviewed Mr McKenzie, and referred him to the mental health team at his request. On 18 January 2019, a mental health nurse assessed Mr McKenzie, who seemed to have settled and said he had no current thoughts of self-harm.

HMP Brixton: 30 January 2019 onwards

42. On 30 January, Mr McKenzie transferred to Brixton at his own request. Staff noted his recent history of self-harm and depression and his current medication, and he was referred for a mental health assessment.
43. On 31 January, he had a secondary health screen with Nurse A who reviewed his medical history with him.
44. On 4 February, a nurse carried out the mental health assessment. Mr McKenzie said that he was happier at Brixton. He spoke about his deliberate self-harm in December and said he had felt bullied by other prisoners at Wandsworth and he guessed he had been feeling “paranoid”. He said he had stopped taking his medication and had no thoughts of self-harm and did not need the help of the mental health team. The nurse referred him to the Forward Trust (who help offenders address issues around drug and alcohol misuse).
45. On 4 March, Mr McKenzie had a tearful conversation with a prison health trainer employed by Care UK. He said that his mental health was getting worse every day and that he was feeling anxious, depressed and hopeless. He said he wanted to address his substance misuse and mental health issues, to improve his family relationships and to sort out his accommodation and employment for after he was released, but that he was struggling with motivation. He also told her that he felt victimised by members of staff on the wing. She recorded in his medical notes that he needed some work to help his mental wellbeing and referred him to the Health and Wellbeing team. She did not report his bullying allegations and no further action was taken.
46. Mr McKenzie was discharged from the Health and Wellbeing team’s caseload as he failed to attend three appointments.
47. Mr McKenzie did not go to his first appointment with a Forward Trust counsellor on 28 March, but eventually saw one on 5 April. Mr McKenzie told her that he had previously used cannabis, cocaine and MDMA and he was in prison for selling drugs. He subsequently attended substance misuse workshops and completed in-cell work packs.
48. In March, April and May, Mr McKenzie’s prison record contains entries from staff praising him for good work and a positive, helpful attitude.

49. Mr McKenzie's offender supervisor saw him on 8 April to discuss his release which was due on 29 June. As he did not have a release address, he said he would contact Mr McKenzie's offender manager (community probation officer) to discuss referring him to an Approved Premises (a probation hostel).
50. Mr McKenzie seemed positive about the future when he spoke to his key worker on 13 April. They discussed his training course, employment and his family. When she saw him again on 9 May, an officer recorded that Mr McKenzie said he was looking forward to being released, though he still had nowhere to live. On 21 May, she told Mr McKenzie that the offender management unit had found approved accommodation for his release and she noted that he was happy about this, although he would have preferred private rented accommodation. This was the last note in Mr McKenzie's prison record until 4 June.
51. His medical record shows that at the beginning of May, Mr McKenzie complained that he could not sleep because of back pain. Prison GPs prescribed him pain relief and gave him ear plugs to help him sleep.
52. Mr McKenzie's family gave the investigator a copy of a text conversation that Mr McKenzie had with a friend on 30 May. He said he was having the worst day of his life and complained of feeling targeted by staff. He said they were talking loudly outside his door trying to provoke him, turning his power off, and not letting him out of his cell when they should have done. There is no record that Mr McKenzie spoke to officers about this before he died.

4 June 2019

53. On the morning of 4 June, Mr McKenzie's cellmate was released from prison. A supervising officer (SO) subsequently noted that Mr McKenzie appeared really stressed and in low mood and said that "life has caught up with him and he could not cope any longer". He noted that Mr McKenzie had asked to be locked in his cell and later tried to prevent staff entering. At interview, the SO said that Mr McKenzie told him something personal and said that he had ruined somebody's life many years previously and had a longstanding plan to apologise to the person, then to take his own life.
54. As he had a meeting to attend, the SO reminded Mr McKenzie of the support available from the Samaritans and prison Listeners and said that they would continue the conversation later. He told an officer to keep an eye on Mr McKenzie as he was distressed, and told the officer to start ACCT monitoring, which he did at about 9.30am. Officers were to check on Mr McKenzie at least once an hour.
55. Mr McKenzie went back to his cell, where he moved his bed and cupboard to barricade the door. The SO tried to talk to him, but Mr McKenzie would not respond. He then told an officer to use the anti-barricade key to open Mr McKenzie's door. The SO went into the cell, but Mr McKenzie was tearful and did not want to speak to him.
56. Nurse A was on the wing and told the SO that she thought Mr McKenzie would speak to her as she had had previous dealings with him. In interview, she said that Mr McKenzie initially indicated that he did not want to talk to her in front of the prison officer at the door. She said the officer left, but Mr McKenzie still did not

want to talk to her and asked her to leave the cell. She did not make a note in Mr McKenzie's medical record or discuss this encounter with her colleagues and she did not refer him for a mental health assessment.

57. The SO completed the ACCT immediate action plan. He noted that Mr McKenzie should remain in his current cell and share with a cellmate. Staff were to check on him at least once per hour until he had an assessment interview. The plan also noted that Mr McKenzie had been referred to the mental health team but there is no evidence in prison or healthcare records that a referral was made.
58. A counsellor arrived for a scheduled counselling appointment with Mr McKenzie, but he did not want to go ahead and they agreed to postpone the appointment to 11 June.
59. At 11.30am, an officer opened the cell door for Mr McKenzie to collect his meal, but Mr McKenzie said that he did not want any food. The officer asked him if he wanted it collected and brought to him, but he refused.
60. Mr McKenzie remained in his cell all day and continued to put furniture behind his door and block his observation panel. Although officers noted in his ACCT ongoing record that he did not want to engage with staff, he unblocked his observation panel when asked so they could see that he was alright. Officers recorded that Mr McKenzie slept overnight.

5 June 2019

61. On the morning of 5 June, an SO noticed that Mr McKenzie had not had an ACCT assessment, which should have taken place within 24 hours of the ACCT being opened. She tried to arrange an assessment in time, but was told that there were no trained ACCT assessors available.
62. Later that morning, officers took a new cellmate to Mr McKenzie's cell, but he said he did not want to share and kicked the cell door open as officers were closing it and argued with them on the landing. They tried to persuade him back into his cell, but Mr McKenzie tried to force his way past them. The officers restrained him, and put him back into his cell. The other prisoner was taken to a different cell. No one from the healthcare team saw Mr McKenzie following the use of force.
63. An SO tried again to get a trained officer to conduct Mr McKenzie's ACCT assessment interview. She asked a custodial manager (CM) to speak to the orderly officer (in charge of the running of the prison) for help arranging it but was told that there were no ACCT assessors available.
64. Officers continued to carry out ACCT checks on Mr McKenzie. He did not eat lunch. During the afternoon, he repeatedly blocked his observation panel. At 5.30pm, an officer noticed that Mr McKenzie had not collected his evening meal again. The officer took the meal to his cell. Mr McKenzie was reading and said he did not want his food. The officer said that he should try to eat, and left the food in the cell. Mr McKenzie thanked him.
65. There are no observations noted on the ACCT document between 4.00pm and 6.05pm. However, CCTV shows that Nurse A went to see Mr McKenzie at

approximately 5.40pm and spoke to him from outside his closed cell door for seven minutes. She told us that, although she was not working on the wing that day, she had gone to see Mr McKenzie because she was concerned that he had been feeling “down” the previous day. She made a note in his medical records that he was low in mood and tearful. She said she encouraged him to eat and he agreed to try. He talked about going to a counselling appointment that Friday.

66. At interview Nurse A said that she asked a prison officer to “keep an eye” on Mr McKenzie, although she did not record this in his medical notes. She did not write in the ACCT document and there is no corresponding entry in the wing observation book. She said she did not know that he was on an ACCT.
67. At about 7.00pm, two officers were checking prisoners before they handed over to night staff. An officer reached Mr McKenzie’s door at 7.14pm. The observation panel was covered, and the officer knew that Mr McKenzie had been blocking the panel all day. The officer called to Mr McKenzie but received no reply, so he unlocked the cell door. The door was blocked by a cupboard, which he pushed aside. He found Mr McKenzie hanging by a ligature made from a torn bed sheet attached to the window bars.
68. He called another officer and went into the cell. An officer ran to the stairway and called to attract the attention of more staff, then ran back to the cell. He supported Mr McKenzie’s weight while an officer cut the ligature, and they lowered Mr McKenzie to the floor. Mr McKenzie was not breathing and the officers could not detect a pulse. Other officers arrived and moved Mr McKenzie out onto the landing. An officer started cardiopulmonary resuscitation (CPR).
69. About five minutes after the officer found Mr McKenzie hanging, a CM radioed a code blue medical emergency (meaning a prisoner is unable to or is having difficulty breathing). This prompted the control room to call for an ambulance.
70. Staff applied a defibrillator to Mr McKenzie, but it could not find a heartbeat. Healthcare provision at Brixton is not 24-hour and medical staff had finished duty at 6.30pm. Officers continued CPR until paramedics arrived at 7.24pm. They provided medical aid to Mr McKenzie until, at 9.06pm, they pronounced that he had died.
71. After Mr McKenzie died, police found a makeshift weapon in his pocket and an undated note in which he talked about taking his own life.
72. Officers found a further note when they were searching the cell on 8 July. Again, Mr McKenzie wrote about killing himself in the note, which the prison passed to the police.

Contact with Mr McKenzie’s family

73. One of the prison’s managers, broke the news of Mr McKenzie’s death to his mother. Mr McKenzie’s mother and sister subsequently visited HMP Brixton. In line with Prison Service policy, Brixton offered a contribution to the costs of Mr McKenzie’s funeral.

Support for prisoners and staff

74. After Mr McKenzie's death, the duty 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.
75. The prison posted notices informing other prisoners of Mr McKenzie'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 McKenzie's death.

Post-mortem report

76. The post-mortem examination found that Mr McKenzie died as a result of hanging. The pathologist noted that no other significant injuries were found to suggest that Mr McKenzie had been involved in a violent altercation with a third party.
77. There were traces of cannabis in Mr McKenzie's system when he died, though toxicology tests were unable to determine exactly when he had taken the drug. There were also traces of quetiapine (an antipsychotic medication that had not been prescribed to Mr McKenzie and which may be misused for its euphoric effects).

Findings

Assessment and management of Mr McKenzie's risk

78. Mr McKenzie had a number of potential risk factors for suicide and self-harm: a previous history of self-harm and suicide attempts; previous mental ill health; feelings of guilt about unacceptable behaviour to a family member in the past; a history of substance misuse (which may have put him at risk of debt and bullying); alleged bullying by staff; and mental distress on the last two days of his life. We have considered whether these factors were taken into account in assessing and managing his risk to himself.

Opening the ACCT

79. An SO appropriately identified that Mr McKenzie was at risk of suicide or self-harm after their conversation on 4 June and asked officers to start ACCT monitoring. However, we are concerned that staff failed to assess or manage Mr McKenzie's risk adequately in the brief time that the ACCT was in place.
80. Prison Service Instruction (PSI) 64/2011, which sets out how staff should manage prisoners at risk of suicide or self-harm, requires that a manager should arrange for an ACCT assessment to take place within 24 hours. They should also notify the healthcare team within an hour. The SO ticked the form to say that he had referred Mr McKenzie for an assessment and notified healthcare staff.
81. In interview, the SO said that he had asked another SO to arrange the assessment. She told the investigator that she was told that it had been arranged. When she realised it had not been done on the morning of 5 June, she tried to arrange an assessment, but could not.
82. The ACCT assessment is an in-depth assessment of a prisoner's risk and protective factors, which should inform what support measures are put in place. As there was no assessment, there was no multidisciplinary case review and there was no plan to support Mr McKenzie through this time of crisis, other than observing him once per hour.
83. No one notified the healthcare team that Mr McKenzie was subject to ACCT monitoring. What Mr McKenzie told an SO on 4 June about his guilt over his previous behaviour is very similar to what he said when he self-harmed in December 2018. On the previous occasion he had been referred to a psychiatrist who diagnosed a brief psychotic episode and prescribed medication. If healthcare had been told that an ACCT had been opened on 4 June and participated in the first ACCT review, it is possible that Mr McKenzie's medical records might have been reviewed in detail and the similarity of his presentation with that of December 2018 might have been picked up - although we cannot be certain of this.
84. The Head of Residence and Safety told us that since Mr McKenzie's death, the prison has trained additional ACCT assessors. They have also introduced a new audit for newly-opened ACCT documents to ensure all required actions are completed within 24 hours.

Recording

85. Both an SO and Nurse A spoke to Mr McKenzie about what was troubling him on 4 June but neither recorded the extent of their conversations in the ACCT record. Nurse A made no entry in the ACCT record following her conversation with him on 5 June. We are concerned that this meant that other staff did not know the extent of Mr McKenzie's distress risk, so inevitably failed to manage his risk appropriately.
86. Nurse A said she did not make a note in the ACCT record because she did not know an ACCT was in place. We are concerned that although she was sufficiently worried about Mr McKenzie on 4 June to go out of her way to see him on 5 June, she did not consider opening an ACCT or escalating her concerns to prison staff.

Level of risk

87. We consider that the use of force on Mr McKenzie, his repeated barricading and his food refusal should have prompted staff to reassess his level of risk on 5 June. We are concerned that staff did not consider if his risk to himself was escalating and that he remained subject to hourly checks without further consideration.
88. We found many of the same issues in an investigation into a previous death at Brixton in May 2018. While we recognise that the prison has tried to address the failings, we make the following recommendation:

The Governor and the Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, in particular, that:

- **all staff know they should open an ACCT if they are concerned that a prisoner may be at risk;**
- **ACCT assessments are completed promptly, at least within the required timescales;**
- **healthcare staff are notified when a prisoner is made subject to ACCT monitoring;**
- **staff review the prisoner's risk following events or behaviour that suggest risk may have increased.**

Bullying

89. Solicitors acting for Mr McKenzie's family asked if there was any evidence of Mr McKenzie being bullied by staff. The investigator saw a copy of a text exchange Mr McKenzie had with a friend on 30 May, alleging that staff were trying to provoke him by saying things outside his cell door and turning his power off.
90. Mr McKenzie had also told a prison health trainer on 4 March that he felt victimised by staff on the wing. As a result, she referred him to the Health and Wellbeing team. She did not report his allegations or communicate his concerns to the security department or the wing manager. She told the investigator that she did not know how to submit an intelligence report or start ACCT monitoring. As a result, Mr McKenzie's allegations were not known to prison staff and were never investigated.

91. There is no record that Mr McKenzie spoke to officers (including his key worker) or other healthcare staff about feeling victimised. There are no intelligence reports relating to him being the victim of bullying by staff or prisoners. The only negative entry by staff in his prison record during his time at Brixton was in February when he was placed on the basic regime for a week after refusing to move wings. He subsequently moved wings and was reported to have settled well and his prison record shows that staff praised him for good behaviour and a helpful attitude in March, April and May. He engaged well with his key worker (who he last saw on 21 May) and entries by other staff describe him as “polite” and happy to speak to them.
92. We note that his cell was opposite the wing office and that it is possible that this was why he could hear officers speaking outside his door. We also note that Mr McKenzie appeared to have paranoid thoughts at times. However, this does not necessarily mean that what he said about staff victimising him was untrue. Although the balance of evidence suggests that Mr McKenzie had a good relationship with staff until at least the end of May, we cannot say categorically that he was not being bullied by staff.
93. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff know how to report allegations of bullying and that all such allegations are investigated.

Substance misuse

94. Post-mortem toxicology tests showed that Mr McKenzie had used both cannabis and quetiapine (an antipsychotic medication that he had not been prescribed) before he died. This raises the question of whether he may have been in debt for drugs, or whether drug use may have affected his state of mind before he hanged himself.
95. Mr McKenzie had a history of drug use and was suspected of involvement in the prison drug culture. However, we found no evidence to suggest that Mr McKenzie was in debt or in conflict with other prisoners because of drugs. The clinical reviewer considered that his substance misuse treatment was appropriate and he appeared to engage well with substance misuse work.
96. In a report into an investigation into a death at Brixton in May 2018, we recommended that the Governor should identify key drug issues and revise the prison’s local drug strategy. HMPPS accepted this recommendation and undertook to revise the strategy by September 2019. As this undertaking was given after Mr McKenzie’s death, we do not repeat this recommendation.

Emergency response

97. Prison Service Instruction 3/2013 requires prisons to have an emergency response code protocol to ensure that an ambulance is called automatically in a life-threatening medical emergency.
98. When an officer found Mr McKenzie hanging, he called for staff assistance. An officer responded to the call, and he also called for staff assistance. The two

officers said they were aware of the medical emergency code system but did not use it. No one radioed a code blue emergency (which would have prompted the control room to call an ambulance) until the CM did so. Body-worn video camera footage suggests that this was up to five minutes after Mr McKenzie was first seen hanging.

99. The emergency code system ensures that the control room knows that an ambulance is required, so it is important that staff call emergency codes on the radio as soon as possible. It appears that the delay in this case did not affect the outcome for Mr McKenzie since officers started CPR quickly, but a delay could be critical in other medical emergencies. We make the following recommendation:

The Governor should remind staff of the importance of using the correct codes as soon as possible in an emergency, and the potential consequences of not doing so.

Clinical care

100. The clinical reviewer concluded that much of Mr McKenzie's healthcare was equivalent to that which he could have expected in the community. Persistence was shown in trying to refer him for counselling when he failed to engage with the process.
101. However, she said that he may also have benefitted from a referral to the mental health inreach team for a more formal assessment of his mental state when the ACCT was opened on 4 June.

Use of force

102. Guidance on the use of force is contained in Prison Service Order (PSO) 1600, which says that when force is used, a doctor or nurse must examine the prisoner as soon as possible and complete an F213 form to note any injuries.
103. We are concerned that when Mr McKenzie was restrained on 5 June, he was not seen by a member healthcare staff. Although it is clear from the post-mortem report that Mr McKenzie did not sustain any significant injuries during the restraint, the extent of his emotional distress may have been apparent if he had been seen by healthcare staff. This may, therefore, have been a missed opportunity to identify his level of risk and put appropriate support in place. We make the following recommendation:

The Governor and Head of Healthcare should ensure that prisoners are examined by a doctor or nurse in line with PSO 1600 after any use of force.

Nurse A

104. In the immediate aftermath of Mr McKenzie's death, the prison became aware that Nurse A had known Mr McKenzie before he entered prison: he had previously had a relationship with one of her daughters and they had a child together. His prison records note that he had a history of domestic violence against his former partner in 2014 and that he was considered to be a risk to both Nurse A and her daughter. He

had also listed someone with the same surname as his next of kin and she had visited him twice at Wandsworth in 2018.

105. Nurse A carried out Mr McKenzie's secondary health screen at Brixton on 31 January 2019 and saw him several times after that, including on the evening of his death. Nurse A said at interview that she had not recognised Mr McKenzie and he had not recognised her. She denied that she had ever had any training on declaring any possible conflict of interests (although her records show that she had attended such training). She said she only realised who Mr McKenzie was on 7 June when her daughter told her that he had hanged himself at Brixton.
106. In December 2019, the clinical reviewer wrote to Care UK, Nurse A's employers, to express her concerns about this and other aspects of her professional practice:
 - on 31 January 2019, she made a retrospective entry about a head injury Mr McKenzie sustained on 18 December 2018 (when he was at Brixton) although there is nothing in his records at the time about a head injury of any kind and the nurse cannot recall where this information came from or why she entered it retrospectively;
 - she had accessed Mr McKenzie's medical records often, without any obvious reason for doing so;
 - although she had seen Mr McKenzie several times, she had not recorded the rationale for doing so;
 - although she had referred Mr McKenzie to healthcare colleagues on occasions, after she said he had stopped her on the wing as she was passing, she had not recorded these conversations in his medical notes; and
 - although she had a long conversation with Mr McKenzie in his cell on 4 June, she did not record this until 5 June, when her record keeping is so poor that it is impossible to tell what happened on each day and there is insufficient detail about what was said on 4 June.
107. It is difficult to say whether any of this has any bearing on Mr McKenzie's death. However, we are concerned that Nurse A's informal visits to Mr McKenzie on 4 and 5 June may have led officers to assume (incorrectly) that Mr McKenzie was being seen by healthcare and therefore obscured the fact that he had not been referred to healthcare when the ACCT was opened.
108. We are also concerned that although she was sufficiently concerned about Mr McKenzie's low mood on 4 June to return to see him informally on 5 June, she did not share her concerns with prison or healthcare colleagues, and did not consider opening an ACCT or making a note in his ACCT record. This was a missed opportunity to assess Mr McKenzie's risk and to consider what support might be put in place.
109. Nurse A told us at interview that she had been suspended by Care UK and banned from working in prisons. We understand that the Nursing and Midwifery Council is currently considering her fitness to practice. We do not, therefore, make a recommendation.

**Prisons &
Probation**

Ombudsman
Independent Investigations

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

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

T | 020 7633 4100