

**Prisons &
Probation**

Ombudsman
Independent Investigations

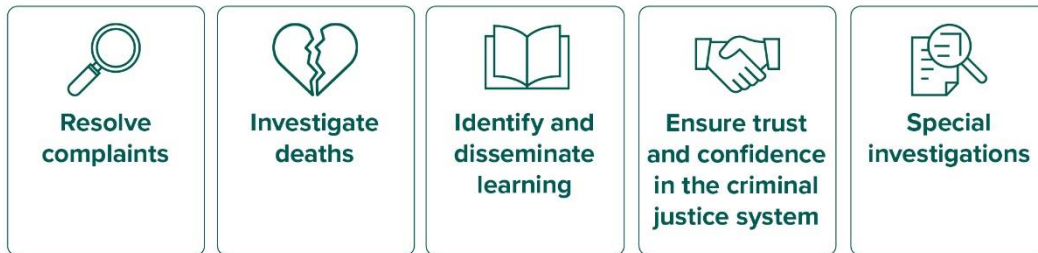
Independent investigation into the death of Mr Ian Nixon, a prisoner at HMP Brixton, on 8 July 2020

A report by the Prisons and Probation Ombudsman

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE



© Crown copyright, 2023

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3

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

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

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 Ian Nixon died from a urinary tract infection on 8 July 2020 at HMP Brixton. This was caused by cachexia (weakness and wasting of the body) as a result of surgery for previous bladder cancer which caused bowel adhesions. He was 66 years old. I offer my condolences to his family and friends.

The clinical reviewer found that the care that Mr Nixon received at Brixton was equivalent to that which he could have expected to receive in the community.

In April 2020, healthcare staff thought that Mr Nixon had constipation, but when he went to hospital, he needed surgery for a bowel obstruction. The clinical reviewer found that although it was difficult to diagnose a bowel obstruction, a prison GP should have assessed him when he presented with constipation. I am concerned that healthcare staff did not adequately monitor Mr Nixon when he lost weight.

I am also concerned that the officer who conducted the morning roll check on 8 July signed to confirm that it was completed when CCTV footage is clear that she did not check on Mr Nixon.

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 2022

Contents

Summary 1

The Investigation Process.....3

Background Information.....4

Key Events.....5

Findings10

Summary

Events

1. In August 2019, Mr Ian Nixon was sentenced to three and a half years in prison for sex offences. On 14 November, he was transferred to HMP Brixton.
2. Mr Nixon had had bladder cancer a number of years earlier, following which he had had his bladder replaced and prostate removed.
3. On 18 April 2020, Mr Nixon was sent to hospital after he complained about having worsening constipation for four days. He had a laparotomy (an abdominal operation to remove a bowel obstruction) and a colostomy (an operation to divert one end of the colon through a stoma (opening) in the stomach). On 13 May, Mr Nixon returned to Brixton.
4. On 14 May, a prison GP saw Mr Nixon and noted that he felt well but was weak. She asked him to eat and drink small amounts on a regular basis and noted that his urine output should be monitored and that he should be encouraged to move around. Later that day, a nurse saw Mr Nixon and noted that there was urine on the floor of his cell, that his clothes and bedding were soaked and that his catheter bag was empty. The nurse sent him back to hospital.
5. On 18 May, Mr Nixon returned to Brixton. Nursing staff saw him twice daily. On 22 May, a prison GP saw that Mr Nixon had a small hole in the right side of his pelvis which was leaking fluid and suspected that this was either urine or signs of an infection. The GP sent him back to hospital.
6. On 24 June, Mr Nixon returned to Brixton. A prison GP noted that he was cachectic (wasting away) but was calm and understood his condition.
7. On 1 July, a prison GP noted that Mr Nixon was frail and refused to get out of bed and to get dressed.

Events of 7 and 8 July

8. Between 7.45pm and 8.00pm on 7 July, an Operational Support Grade (OSG) carried out a roll check and saw Mr Nixon sleeping in the foetal position. The OSG had no reason to go back to Mr Nixon's cell that night.
9. At about 5.45am on 8 July, the OSG handed over to an officer.
10. At 6.00am, the officer signed to confirm that the roll check was complete. However, we are concerned that CCTV footage shows that the officer did not conduct the roll check and did not go to Mr Nixon's cell.
11. At about 7.55am, a nurse and an officer went to Mr Nixon's cell door to give him his medication. The officer saw Mr Nixon half kneeling at his bed, with his upper body and head leaning onto the bed, with his eyes open. The nurse could not find a pulse and noticed that his hand was stiff. The nurse moved Mr Nixon to the floor. At 7.57am, the officer radioed a medical emergency code blue (which indicates that a prisoner is unconscious or not breathing).

12. A prison GP went to Mr Nixon's cell, found that Mr Nixon had rigor mortis and said that it was futile to attempt resuscitation. A post-mortem examination established that Mr Nixon died of an ascending urinary tract infection as a result of cachexia (wasting of the body) as a result of surgery for previous bladder cancer.

Findings

Clinical care

13. The clinical reviewer found that the clinical care that Mr Nixon received at Brixton was equivalent to that which he could have expected to receive in the community. She noted that the care and considerable efforts made by the nursing team after Mr Nixon's third discharge from hospital was an example of good practice.
14. However, the clinical reviewer noted that although diagnosing a bowel obstruction was clinically challenging, a prison GP should have assessed Mr Nixon when he reported having constipation for several days.
15. The clinical reviewer found that healthcare staff did not accurately record what Mr Nixon was eating and drinking and it was therefore not possible to work out his total daily consumption.

Roll check

16. The officer who signed to confirm that she had conducted the roll check for 6.00am on 8 July did not carry out the check and falsified the document. The officer resigned from the Prison Service and the investigator was therefore unable to interview her. However, it is unlikely that completing the roll check would have made a difference to the outcome for Mr Nixon because at 7.55am, a prison GP found that Mr Nixon had rigor mortis.

Recommendations

- The Head of Healthcare should ensure that healthcare staff are aware of the symptoms of acute abdominal illness and take appropriate steps to address their cause.
- The Head of Healthcare should ensure that there is a system in place to record a prisoner's daily consumption when they need close dietary supervision.
- The Governor should ensure that staff conduct roll checks in line with local policy, including that they:
 - complete a visual check of prisoners to ensure they are safe and well; and
 - ask prisoners to uncover their cell door observation panels so that they can see them.

The Investigation Process

17. 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. A custodial manager responded and was interviewed by telephone on 24 August 2020.
18. The investigator obtained copies of relevant extracts from Mr Nixon's prison and medical records.
19. NHS England commissioned a clinical reviewer to review Mr Nixon's clinical care at the prison. Between 25 August and 3 September 2020, the investigator and clinical reviewer jointly interviewed five members of staff by telephone.
20. We informed HM Coroner for Inner South London of the investigation. He gave us the results of the post-mortem examination. We have sent him a copy of this report.
21. The Ombudsman's family liaison officer wrote to Mr Nixon's sister to explain our investigation. She was concerned that from May 2020, Mr Nixon's physical and mental health was deteriorating, and he was in pain. She was also concerned about the frequency of Mr Nixon's admissions to hospital and returns to prison. We have addressed her concerns in our report and in the clinical review.
22. We shared the initial report with the Prison Service. There was one factual inaccuracy.
23. We shared the initial report with Mr Nixon's sister. She reported no factual inaccuracies. Mr Nixon's sister had concerns regarding the contact that she received from prison staff regarding Mr Nixon's health which have been addressed by separate correspondence.

Background Information

HMP Brixton

24. HMP Brixton is a medium security resettlement prison in London that holds up to 810 convicted and sentenced adult male offenders. Practice Plus Group, an independent company providing health and social care, provides healthcare services. The prison has five wings.

HM Inspectorate of Prisons

25. The most recent inspection of HMP Brixton was in March 2019. Inspectors reported that there had been a transformation in some key areas of the prison's performance. They noted Brixton's determined, pragmatic and bold approach to dealing with illicit drugs and that this had led to a reduction in their availability and a decrease in violence.
26. Inspectors reported that health services were good. They found that the healthcare centre needed redecoration and did not comply with infection prevention and control standards. They noted that there were long waiting times for bowel screening services.

Independent Monitoring Board

27. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to August 2020, the IMB reported that until lockdown, the prison was making good progress, with improvements in safer custody, better communication with prisoners and efforts to improve the prison environment.
28. Since March 2020, the priority has been on keeping prisoners and staff safe by severely limiting the number of prisoners out of their cells at one time. The IMB reported that they were impressed by the speed and sensitivity with which the new Governor and her staff implemented revised systems of working to respond to the threats of COVID-19. Overall, they noted that healthcare was good, and the number of staff and the hours covered for physical and mental healthcare had increased.

Previous deaths at HMP Brixton

29. There were two deaths from natural causes and one self-inflicted death at HMP Brixton in the two years before Mr Nixon's death. Two prisoners have died from natural causes since Mr Nixon's death, both of which were as a result of COVID-19. There are no significant similarities between our findings in this investigation and those of the other deaths.

Key Events

30. On 14 August 2019, Mr Ian Nixon was sentenced to three years and six months in prison for sex offences. On 14 November, he was transferred to HMP Brixton.
31. He had had bladder cancer a number of years earlier, and subsequently had his bladder replaced and prostate removed.
32. On 21 November 2019, a prison GP saw Mr Nixon who told her that he was incontinent of urine.
33. On 14 April 2020, Mr Nixon told a nurse that he had constipation, and was given medication. The following day, a prison GP reviewed Mr Nixon and thought that the constipation may be due to his use of codeine (a painkiller).
34. On 18 April, Mr Nixon's condition worsened. A nurse saw Mr Nixon, who told him that he felt sick, that he was vomiting throughout the night and had not been able to open his bowels. The nurse noted that his vital signs were within the normal range. Later that day, another nurse saw Mr Nixon, who said that he was still vomiting what he described as 'ground coffee'. The clinical reviewer said that this could be a sign of internal bleeding in the stomach. The nurse noted that Mr Nixon was dehydrated and had sunken eyes. He sent him to hospital.
35. When Mr Nixon went to hospital, he was restrained by a single handcuff and in hospital by an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer).
36. On 23 April, Mr Nixon had a laparotomy and a colostomy.
37. Before Mr Nixon had surgery, prison staff removed his restraints and he remained unrestrained while in the intensive care unit. On 28 April, when Mr Nixon was no longer sedated, prison staff reapplied the escort chain. Prison managers frequently reviewed the use of restraints while Mr Nixon was in hospital.
38. On 13 May, Mr Nixon returned to Brixton. At 6.55pm, Mr Nixon told a nurse who visited him that he was fine. The nurse told him that a wing nurse would see him the next day.
39. That day, a Custodial Manager, the night orderly officer, said that at about 7.30pm, he arrived to start his night shift and said that Mr Nixon was already in his cell. He said that Mr Nixon was placed in a cell on the fourth landing to isolate due to COVID-19 restrictions for newly arrived prisoners and prison staff carried him up the stairs as the lift only went to the third landing. The CM checked on Mr Nixon and was shocked to see him lying in bed in the foetal position. Mr Nixon looked cold and said that he was in pain. The CM got some blankets for him but said that because healthcare staff were no longer in the prison, he was unable to get him any pain relief. The CM asked the OSGs who were working on the wing to check on Mr Nixon every hour throughout the night.
40. At 8.56am on 14 May, a prison GP saw Mr Nixon with a nurse. The GP reviewed Mr Nixon's hospital discharge summary and noted that he had had a small bowel obstruction, that he had a small area of his bowel removed and an end-to-end

anastomosis (the removal of the dead area of the small bowel and the ends joined together). The GP noted that Mr Nixon's previously reformed urinary bladder section had been reshaped. She also noted that he had a suprapubic catheter (a hollow tube to drain urine from the bladder, inserted into the bladder through a cut in the abdomen). She noted that he felt well but was weak. Mr Nixon told her that he had not been able to walk unaided to his cell on the fourth landing. She asked him to eat and drink small amounts regularly. She noted that his urine output should be monitored and that he should be encouraged to move around. Later that day, a nurse noted in Mr Nixon's medical records that she planned to seek an inpatient hospital bed for Mr Nixon and a prison GP prescribed him a nutritional supplement.

41. At 3.42pm, a nurse saw Mr Nixon and noted that there was urine on the floor of his cell, that his clothes and bedding were soaked in urine and that his catheter bag was empty. The nurse gave him clean clothes and bedding, gave him his medication and planned to talk to a prison GP about a possible urine leak. The nurse sent Mr Nixon back to hospital, restrained.
42. The following day, the Head of Security authorised Mr Nixon's restraints to be removed.
43. On 15 May, a nurse telephoned hospital staff about the failed hospital discharge. She told them that before Mr Nixon could return to Brixton, a social care plan should be completed. She told them that there were no healthcare facilities at Brixton and that they did not have an inpatient unit.
44. On 16 May, a nurse was told that the hospital planned to release Mr Nixon to Brixton.
45. On 18 May, a nurse saw Mr Nixon in hospital. She noted that he was able to look after himself, climb stairs and look after his catheter. Mr Nixon told her that he was feeling better than he did before he went to hospital. Later that day, Mr Nixon went back to Brixton.
46. On 19 May, a nurse referred Mr Nixon to social services to assess his needs. Another nurse assessed his risk of having pressure sores, ordered a pressure-relieving mattress and gave him advice on reducing the risk of developing sores. She encouraged him to eat and drink. She noted that there was no urine in his catheter bag and that he was urinating from his penis but had no awareness of this.
47. Nursing staff saw Mr Nixon twice daily. On 21 May, a nurse noted that Mr Nixon appeared a little dehydrated and encouraged him to drink more fluids. She also noted that he felt low and apathetic, so she made an appointment for him to see the wellbeing team. Later that day, he was referred for counselling and a mental health assessment. A prison GP saw Mr Nixon and was also concerned that he was dehydrated. That evening, a nurse noted that a prison officer saw that urine was leaking from Mr Nixon's catheter, that there was urine on the floor and that his bedding was wet. He gave Mr Nixon clean bedding.
48. On 22 May, a prison GP and a nurse saw Mr Nixon. The GP saw that there was a small hole in Mr Nixon's pelvis which was leaking fluid. He thought that this was either urine or signs of an infection. The GP sent him to hospital, unrestrained.

49. A nurse saw Mr Nixon in hospital and spoke to hospital staff about his care. She found that he felt low, was not complying with his treatment and did not want to go back to Brixton. She frequently telephoned hospital staff for updates about Mr Nixon's health and treatment. Prison and healthcare staff planned for Mr Nixon to go back to Brixton. On 17 June, a nurse saw Mr Nixon in hospital. She noted that he was alert but had visibly lost weight, was not eating well, was bored in hospital and wanted to go back to Brixton. The nurse noted that he was sometimes faecally incontinent and had a catheter. She noted that he used a Zimmer frame to walk and had not been assessed to climb stairs.
50. On 24 June, Mr Nixon returned to Brixton. Two nurses completed a pressure sore assessment. They found that Mr Nixon had two areas of skin damage at the top of his left foot and four areas of damage on top of his right foot.
51. Nurses provided daily care for Mr Nixon. On 25 June, a prison GP saw Mr Nixon. She encouraged him to eat and drink more to support his recovery. She noted that he was cachectic but was calm and understood his condition.
52. On 28 June, a nurse saw Mr Nixon and carried out a mental health review. She noted that his low mood may be related to his physical health and life stresses. At a multidisciplinary team meeting, healthcare staff planned to see Mr Nixon three times a day and to send him back to hospital if his health significantly deteriorated.
53. On 1 July, a prison GP saw Mr Nixon and noted that he was frail and cachectic. The GP noted that Mr Nixon refused to get out of bed or get dressed.

Events of 7 and 8 July

54. On 7 July, a prison GP and a nurse saw Mr Nixon. The GP noted that he was not eating. Mr Nixon sat up in bed. The GP noted that his pressure sore areas were intact. At 4.07pm, a Healthcare Assistant (HCA) took Mr Nixon's observations which were within the normal range.
55. Between 7.45pm and 8.00pm, an OSG carried out a roll check and saw Mr Nixon lying in bed. He saw that he was sleeping in the foetal position. He saw that his hand moved, and he also saw his face. He noticed that Mr Nixon had a thin face and thin hands and made a comment to his colleague that Mr Nixon looked old. He had no reason to go back to Mr Nixon's cell again that night.
56. At about 5.45am on 8 July, the OSG gave Officer A a handover. The OSG said that he explained to the officer what to do because the officer told him that she had never worked on Mr Nixon's wing before and did not know what to do.
57. At 6.00am, Officer A signed to confirm that the roll check was complete. CCTV footage shows that she did not carry out the roll check or go to Mr Nixon's cell. The roll check document shows that Mr Nixon was the only prisoner living on the ground floor of G wing at that time.
58. Officer B said that she was a trainee officer and had worked the night shift, shadowing the OSG. She said that at about 6.00am, shortly before the OSG left G wing, Officer A arrived on the wing. The OSG told Officer A that the roll check had been done but 'another one needs to be done'. Officer B said that she did not know what this meant because she had not previously worked on a prison wing. She said

that Officer A was based in the wing office (on the ground floor of G wing). She said that at 7.00am, a male officer arrived at G wing and Officer A handed over to him and they left the wing to go home.

59. At about 7.55am, a nurse asked Officer C to open Mr Nixon's cell door to give him his medication. Officer C saw that Mr Nixon was half kneeling at his bed, with his upper body and head leaning on the bed, with his eyes open. The nurse called to him, checked for a pulse and noticed that his hand was stiff. He moved Mr Nixon to the floor. At 7.57am, Officer C radioed a medical emergency code blue.
60. A prison GP and a nurse went to Mr Nixon's cell. The GP saw that Mr Nixon was lying on the floor, but his back was curved so that he was not lying flat, and his arms were sticking up in the air. The GP found that he was cold, his eyes were wide open, slightly opaque, fixed and staring. When he tried to move Mr Nixon, he noticed that he had rigor mortis. He said that it was futile to attempt resuscitation and the nurses, who had arrived at the cell, agreed with the decision. He said that he estimated from his medical experience that Mr Nixon had been dead for between two and four hours.

Contact with Mr Nixon's family

61. On 8 July, the Deputy Governor appointed an officer as the family liaison officer (FLO). At 9.05am, the FLO telephoned Mr Nixon's sister, in line with national instructions on managing the risk of COVID-19 in prisons, told her that he had died and offered his condolences.
62. The FLO remained in contact with Mr Nixon's sister. Mr Nixon's funeral took place on 27 July. The prison contributed to its cost in line with national instructions.

Support for prisoners and staff

63. After Mr Nixon's death, the Deputy Head of Residence debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
64. The prison posted notices informing other prisoners of Mr Nixon'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 Nixon's death.

Post-mortem report

65. A post-mortem examination established that Mr Nixon died from an ascending urinary tract infection as a result of cachexia associated with previous carcinoma of the bladder, which was operated on, resulting in bowel adhesions (weakness and wasting of the body due to bladder cancer).

Inquest

66. The inquest into Mr Nixon's death was heard on 16 October 2023, with a narrative verdict. The Coroner concluded that after Mr Nixon was diagnosed with bladder cancer in 2008 he went to hospital in 2020 for further treatment and recovered but

Mr Nixon regularly declined antibiotics and good dietary intake and was found unresponsive in his cell on 8 July.

Findings

Clinical care

67. The clinical reviewer concluded that the clinical care that Mr Nixon received at Brixton was equivalent to that which he could have expected to receive in the community. The clinical reviewer found that the care and considerable efforts made by the nursing team after Mr Nixon's third discharge from hospital was an example of good practice. There was a clear nursing plan, and he was seen three times a day. She found that Mr Nixon had appropriate dietary support.

68. In April 2020, Mr Nixon presented with constipation which had worsened over four days. No one from the healthcare team examined him. When he went to hospital, he was diagnosed with a small bowel obstruction for which he needed surgery. While the clinical reviewer noted that the diagnosis of a bowel obstruction could be clinically challenging, she concluded that his symptoms warranted an assessment by a prison GP. We therefore make the following recommendation:

The Head of Healthcare should ensure that healthcare staff are aware of the symptoms of acute abdominal illness and take appropriate steps to address their cause.

69. The clinical reviewer found that healthcare staff did not accurately record what Mr Nixon was eating and drinking and it was therefore not possible to work out his total daily consumption. We make the following recommendation:

The Head of Healthcare should ensure that there is a system in place to record a prisoner's daily consumption when they need close dietary supervision.

70. The clinical reviewer has made two recommendations which are not directly related to Mr Nixon's death, but which the Head of Healthcare will need to address.

Roll check

71. Brixton's local policy on roll checks states that staff should carry out a roll check at 6.00am before day staff start their shift. The policy also states that the roll check should be carried out at three other listed times of the day. The member of staff carrying out the roll check must physically check each cell and count the number of prisoners present. It says that staff should satisfy themselves that prisoners are in their cells by obtaining a clear view of their face and getting a response from them, if necessary.

72. Officer A signed the roll check document for 6.00am on 8 July for G wing to confirm that this had been carried out and was correct. However, CCTV footage shows that she did not complete the check and does not show that she checked Mr Nixon's cell or was in the vicinity of it.

73. On 8 August, Officer A resigned from the Prison Service and the investigator was unable to interview her to find out why the roll check was not completed. We make the following recommendation:

The Governor should ensure that staff conduct roll checks in line with local policy, including that they:

- **complete a visual check of the prisoner to ensure they are safe and well; and**
- **ask prisoners to uncover their cell observation panels so that they can see them.**

**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