Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Julian Woollon on 21 September 2023, following his release from HMP Channings Wood

A report by the Prisons and Probation Ombudsman

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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

Summary

1. 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.

2. Since 6 September 2021, the PPO has been investigating post-release deaths that occur within 14 days of the person's release from prison.

3. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

4. Mr Julian Woollon died from hanging on 21 September 2023, following his release from HMP Channings Wood on 11 September. He was 47 years old. We offer our condolences to those who knew him.

5. Mr Woollon had a history of anxiety, depression and substance misuse and was under the care of both the mental health team and the substance misuse team at Channings Wood. Before being released, he was referred to a community service to support him with his substance misuse. Mr Woollon's pre-release assessment did not flag any specific concerns about his mental health and Mr Woollon indicated that he had no issues, therefore he was not referred to mental health services in the community. We consider that Mr Woollon's community offender manager made the appropriate referrals for him according to his identified need and support was made available to him in the community.

The Investigation Process

6. HMPPS notified us of Mr Woollon's death on 26 September 2023.

7. The PPO investigator obtained copies of relevant extracts from Mr Woollon's prison and probation records.

8. We informed HM Coroner for Plymouth of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

9. The Ombudsman's office contacted Mr Woollon's mother to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond.

10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Channings Wood

11. HMP Channings Wood is a category C training and resettlement prison which holds convicted adult male prisoners. It is managed by HMPPS.

Probation Service

12. The Probation Service work with all individuals subject to custodial and community sentences. During a person's imprisonment, they oversee their sentence plan to assist in rehabilitation, as well as prepare reports to advise the Parole Board and have links with local partnerships to whom, where appropriate, they refer people for resettlement services. Post-release, the Probation Service supervise people throughout their licence period and post-sentence supervision.

Key Events

13. On 9 March 2023, Mr Julian Woollon was charged with intentional strangulation (an offence introduced in 2022 under the Domestic Abuse Act) and was remanded to HMP Bristol.

14. Mr Woollon had a history of anxiety, depression and substance misuse. He had no recorded history of attempted suicide or self-harm and was not subject to suicide and self- harm prevention procedures (known as ACCT) during his sentence.

15. On 9 March, a nurse completed Mr Woollon's initial health screen. Mr Woollon said that he had not previously used drugs, he said he had no thoughts of suicide or self-harm, but mentally, he felt 'mixed up' and needed his medication. He denied using heroin but said he would drink alcohol four times per week. Mr Woollon tested positive for opiates and benzodiazepines.

16. After the nurse finished the health screen, she checked Mr Woollon's record and could see he was being prescribed pregabalin and diazepam on a weekly basis in the community. She informed the on-call GP at the prison to make them aware of the risk of Mr Woollon detoxing from his prescribed medication and sent a task for his medication to be reviewed.

17. A GP at the prison reviewed Mr Woollon's medication and placed him on a diazepam detoxification programme. Mr Woollon was also prescribed 30mg of mirtazapine (an antidepressant) in line with his community prescription.

18. On 4 April, Mr Woollon asked to see the mental health team because he was suffering with anxiety and depression and could not sleep. Mr Woollon was added to the referral list to be seen the following day.

19. The next day, a member of the mental health team completed an assessment of needs with Mr Woollon. Mr Woollon said that he was struggling without his pregabalin, and as a result, he was feeling low in mood. Mr Woollon said he would like support with his pregabalin addiction. She referred him to the substance misuse team.

20. On 6 April, Mr Woollon declined to engage with the substance misuse team and said he wanted a prescription for pregabalin (this medication is considered high risk in prison and is only prescribed in limited circumstances). The substance misuse team told him they would not be able to prescribe this and advised him to speak with the GP.

21. On 18 April, a nurse noted that Mr Woollon was given a short prescription of zopiclone (sleeping tablets) to help him during his court hearing. She advised him to engage with psychological therapies to help him with his anxiety.

22. On 27 April, Mr Woollon was convicted of intentional strangulation and was sentenced to 16 months in prison. He remained at Bristol. When he returned to Bristol from court, he refused to see the nurse and said that he just wanted to go back to the wing.

23. Staff recorded no particular concerns about him in the following weeks however, he described feeling very anxious and not sleeping well. In May he was referred to the talking therapies service and added to the waiting list.

24. On 18 May, Mr Woollon's allocated Community Offender Manager (COM) emailed his Prison Offender Manager (POM) at Bristol and requested any information relating to Mr Woollon's engagement with mental health services and substance misuse services. The POM had only recently been allocated the case; she had not yet met Mr Woollon and was unable to provide much information.

25. On 25 May, Mr Woollon was transferred to Channings Wood.

26. That day, a nurse at Channings Wood completed Mr Woollon's initial health screen. Mr Woollon told her that he had problems with anxiety and depression.

27. On 26 May, during his secondary health screen, Mr Woollon asked to see the mental health team because he wanted to discuss his low mood, anxiety and panic attacks. That day, a member of the substance misuse team saw Mr Woollon for the recovery service induction, but he declined to engage with their service.

28. On 5 June, the COM emailed Mr Woollon's new POM at Channings Wood to arrange a video link meeting for 3 July. The POM did not provide her with any information relating to Mr Woollon's engagement with mental health services or substance misuse services.

29. On 6 June, a nurse completed a mental health assessment. Mr Woollon said that he had felt low in mood when he was in the community and he used to self-medicate with valium and pregabalin, but he wanted to develop skills to manage his anxiety without the use of drugs. They agreed Mr Woollon would benefit from attending an anxiety management group and be issued a self-help booklet on anxiety that he could read in his cell. Mr Woollon was added to the waiting list for group work.

Pre-release planning

30. On 16 June, a member of the substance misuse team saw Mr Woollon again at his request because he had decided he wanted to engage with the substance misuse service. He was then allocated a co-ordinator with Through The Gate (TTG, a service designed for prisoners who need support with preparing for release).

31. On 26 June, a GP at the prison saw Mr Woollon because he was very anxious about a growth on his knuckle that was causing him pain. The GP examined his hand and sent a request for an X-ray. During this appointment, Mr Woollon said that he did not think the 30mg of mirtazapine was enough to control his low mood and anxiety. The GP agreed to increase his mirtazapine to 45mg, and he was also given a prescription of naproxen to help with the pain in his hand.

32. On 28 June, the co-ordinator completed a 12-week pre-release screening assessment. Mr Woollon said that he was very anxious all the time and this was mainly due to the issues he was having with his hand, and he did not think his medication was helping. Mr Woollon was focused on the issues with his hand and wanted to make sure he worked with the GP in the community to improve his symptoms and avoid using pregabalin as pain relief. She sent a request to

healthcare staff for Mr Woollon's medication to be reviewed and referred him to the local community drug and alcohol service, We Are with You (WAWY).

33. On 3 July, the COM had a video link meeting with Mr Woollon. Mr Woollon said he had used heroin in the past and sometimes drank too much, which caused relationship problems.

34. On 7 July, the COM received Mr Woollon's 12-week pre-release screening information which indicated that Mr Woollon did not require a referral to community mental health services.

35. On 8 August, the COM met with Mr Woollon through video link. Mr Woollon appeared anxious and stressed about the condition of his hand. She said that Mr Woollon did not disclose any suicidal thoughts, and if he had, she would have reported this to the prison.

36. That day, the COM completed a Duty To Refer (DTR- The Homelessness Reduction Act 2017 requires prisons and probation services to refer anyone who is homeless or at risk of becoming homeless within 56 days to a local housing authority) to the local council. They advised that Mr Woollon should contact the local authority homelessness team on the day of his release.

37. On 17 July, Mr Woollon was removed from the waiting list for the anxiety management group as he did not have enough time to complete the course before his release on 11 September.

38. On 28 July, a prison GP saw Mr Woollon to discuss the results of the X-ray which confirmed Mr Woollon had osteoarthritis. The GP prescribed 10mg amitriptyline, which was increased to 20mg on 1 September, to help Mr Woollon with the ongoing pain in his hand.

39. On 7 September, the co-ordinator completed a harm minimisation talk with Mr Woollon. They discussed safer drinking, drug use and tolerance levels. Thy also discussed naloxone (a medication used to reverse an opiate overdose) and that this would be available in the community if he felt he needed it.

40. On 9 September, a clerk from the substance misuse team sent a release pack for Mr Woollon to the community services WAWY. Mr Woollon was also given a harm minimisation letter and a naloxone flyer.

41. On 11 September, Mr Woollon was released from Channings Wood with two weeks' worth of prescribed medication, which included amitriptyline, naproxen and mirtazapine. He was not released with naloxone but was made aware he could get it from the community substance misuse team if needed.

Post-release management

42. Following his release, Mr Woollon attended the probation office in Weston-Super-Mare. Another COM covered the initial appointment as his COM was on leave. Mr Woollon signed his licence to confirm he understood the conditions of his licence. Mr Woollon was temporarily staying at his mother's home address.

43. On 13 September, a member of WAWY called the probation office to let the COM know that Mr Woollon had attended their office the previous day and that he appeared very stressed and anxious about missing his appointment. He completed an initial assessment. Mr Woollon told him that he had not used opiates for nine months but asked for a subutex prescription because he was concerned about reverting back to drug misuse. Mr Woollon was not given subutex because he did not meet the threshold for treatment at that time.

44. On 20 September, Mr Woollon was due to attend the probation office for an appointment. However, his mother called his COM and asked her if the appointment could be rearranged because the community GP was making a home visit to see Mr Woollon over concerns about his mental health. (Mr Woollon continued to worry about his hand as his symptoms were getting worse.) The community GP prescribed Mr Woollon medication for his low mood (Mr Woollon died before he could start this medication). The COM agreed and moved the appointment to the following day. Mr Woollon did not attend this appointment.

Circumstances of Mr Woollon's death

45. On 21 September, Avon and Somerset Police informed HMPPS that Mr Woollon had died.

46. Mr Woollon's mother's partner found Mr Woollon hanging in the utility room at their home.

Post-mortem report

47. The post-mortem report gave Mr Woollon's cause of death as hanging.

Findings

Mental health support

48. Mr Woollon had a history of anxiety, depression and substance misuse. He had no known history of attempted suicide or self-harm and was not subject to suicide and self- harm prevention procures (known as ACCT) during this sentence.

49. The mental health services in prison assessed Mr Woollon in a timely manner and staff referred him to support services to help manage his anxiety.

50. Mr Woollon had ongoing issues with his hand while in prison and this made him very anxious. The GP assessed his hand and promptly referred him for an X-ray. The GP also prescribed Mr Woollon medications to help manage the pain.

51. Mr Woollon's community GP was apparently aware of the link between Mr Woollon's mental health deterioration and the osteoarthritis diagnosis. The doctor prescribed Mr Woollon medication to help with his low mood, however Mr Woollon died before he was able to start the prescription. The COM said Mr Woollon appeared desperate for the issues with his hand to be addressed properly and this caused him emotional distress. However, no one working with him in the community considered that he was at heightened risk of suicide.

52. We are satisfied that both prison and probation staff did all they could to manage the risks associated with Mr Woollon's anxiety.

Substance misuse

53. Mr Woollon had a history of substance misuse. While he was in prison, he was seen by the substance misuse team and warned about the risks and dangers of taking drugs. He was also trained in the use of naloxone and where it was available in the community.

54. We found that the substance misuse service at Channings Wood handed over Mr Woollon's care to the community substance misuse provider effectively and ensured that he had continuity of care upon his release. However, Mr Woollon appeared distressed and anxious during a meeting with his substance misuse support worker and was worried about reverting back to drugs. The support worker informed Mr Woollon's COM of his concerns. She had planned to see Mr Woollon on 21 September, but Mr Woollon did not attend.

Adrian Usher
Prisons and Probation Ombudsman **June 2024**

At the inquest held on the 12 August 2024, the Coroner concluded that Mr Woollon died of suicide.

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