

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Simon Follos, a prisoner at HMP Stoke Heath, on 22 August 2023**

**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



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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.

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.

Mr Simon Follos was found hanged in his cell at HMP Stoke Heath on 22 August 2023. He was 49 years old. I offer my condolences to his family and friends.

Although Mr Follos was being managed under suicide and self-harm prevention procedures (known as ACCT) when he hanged himself, staff underestimated his risk and ACCT procedures were poorly managed. Staff did not check on Mr Follos for several hours on the day he died.

We identified similar deficiencies in the way that ACCT monitoring was completed in two previous investigations into self-inflicted deaths at Stoke Heath. We note that HM Inspectorate of Prisons identified weaknesses in the management of ACCT procedures in January 2023, and we have not seen evidence that the necessary improvements had been made by the time of Mr Follos' death.

Mr Follos had a significant history of mental health issues. The clinical reviewer concluded that the care he received was of a good standard and was at least equivalent to that which he could have expected to receive in the community. It is possible that Mr Follos' anxieties about his release might have contributed to the decision to take his life.

A number of prisoners made allegations about the way prison staff had treated Mr Follos. The Governor told us that two of the named prison officers had been dismissed (for unrelated matters) but there was insufficient evidence to warrant an investigation into the actions of other officers. He told us that he tackled staff issues robustly when he had sufficient evidence to do so. We also were not able to establish whether the allegations were true and contributed to Mr Follos' death. HM Inspectorate of Prisons concluded that Stoke Heath was safe. However, we expect the Governor to continue to prioritise safety and address concerns about staff misconduct appropriately.

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

**Adrian Usher**  
**Prisons and Probation Ombudsman**

**April 2025**

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## Summary

### Events

1. Mr Simon Follo had a significant history of mental health issues and had served numerous custodial sentences. On 28 March 2023, he told the police he was psychotic, had a broken bottle and was thinking of hurting someone. Mr Follo was arrested and remanded to HMP Birmingham. He told his offender manager that his actions were a “cry for help”. Mr Follo had been arrested in similar circumstances on at least three previous occasions. While at Birmingham, Mr Follo was monitored under suicide and self-harm monitoring procedures (known as ACCT).
2. On 18 May, Mr Follo was sentenced to ten months in prison for the possession of an offensive weapon. On 30 May, he was transferred to HMP Stoke Heath. Prison records noted that his behaviour was disruptive, and he remained under the care of the mental health team. On three occasions in August, Mr Follo was monitored under ACCT procedures, including at the time of his death. During his time at Stoke Heath, Mr Follo raised concerns about his safety five times.
3. At around 4.30pm on 22 August, staff found Mr Follo hanged from a ligature. They began cardiopulmonary resuscitation (CPR) and asked for emergency assistance. At 5.03pm, a doctor confirmed that Mr Follo had died.

### Findings

4. We are concerned that staff underestimated Mr Follo’s risk to himself and did not start ACCT procedures when they should have done. ACCT monitoring was poorly managed and was closed prematurely. Mr Follo’s ACCT care plan did not address his concerns which meant there was little to support him and address his underlying issues.
5. We found no evidence that Mr Follo’s concerns for his safety were investigated, despite him raising them five times.
6. Three prisoners made serious allegations about the way staff treated Mr Follo at Stoke Heath. We drew these concerns to the Governor’s attention. The Governor told us that there was insufficient evidence to warrant an investigation but that he tackled staff issues robustly.
7. The clinical reviewer concluded that the physical and mental health care that Mr Follo received was of a good standard and was at least equivalent to that which he could have expected to receive in the community.

### Recommendations

- The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with the Prison Safety Policy Framework, including that stringent ACCT quality assurance procedures are in place for senior managers to identify poor practice, learn lessons and, where appropriate, provide staff with refresher training.

- The Prison Group Director for West Midlands should outline in the action plan the steps she has taken to satisfy herself that effective action is being taken to improve ACCT quality assurance at Stoke Heath.
- The Governor should ensure that staff:
  - fully and promptly investigate information about bullying and intimidation;
  - challenge alleged perpetrators appropriately; and
  - support victims effectively and properly consider and address the possible impact on their risk of suicide and self-harm.

## The Investigation Process

8. HMPPS notified us of Mr Follos' death on 22 August 2023.
9. The investigator issued notices to staff and prisoners at HMP Stoke Heath informing them of the investigation and asking anyone with relevant information to contact him. One prisoner responded and asked to speak to the investigator.
10. The investigator obtained copies of relevant extracts from Mr Follos' prison and medical records and watched CCTV and body-worn video camera footage. He also obtained ambulance service records. Mr Follos made no telephone calls during his time at Stoke Heath.
11. NHS England commissioned a clinical reviewer to review Mr Follos' clinical care at Stoke Heath.
12. The investigator and clinical reviewer interviewed 15 members of staff and three prisoners in August, October and November 2023.
13. We informed HM Coroner for Shropshire of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
14. The Ombudsman's office contacted Mr Follos' next of kin, his sister, to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Follos' family had no specific questions.
15. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.
16. Mr Follos' family received a copy of the draft report. They did not make any comments.

## Background Information

### HMP Stoke Heath

17. Stoke Heath is a category C training and resettlement prison. Shropshire Community Health NHS Trust provides healthcare services.

### HM Inspectorate of Prisons

18. The most recent inspection of Stoke Heath was in January 2023. Inspectors reported continuing stability and assessed the prison to be safe and reasonably respectful. Inspectors reported that leaders maintained an overall positive ethos and that the Governor was keen to promote a positive culture.
19. Inspectors reported that staff interactions with prisoners were courteous and professional and 64% of prisoners said they were treated with respect. However, some prisoners reported that some staff were intimidating and some prisoners with protected characteristics reported instances of staff using insensitive and offensive language. Inspectors reported their concern about the number of prisoners who said staff were intimidating and antagonistic towards them.
20. Inspectors noted that the focus on improving safety had been effective and that large reductions in self-harm had been impressive, but the quality of ACCTs was variable. They noted that assessment of risk was not always made clear and was sometimes underestimated, reviews had not been multidisciplinary and care plans lacked meaningful actions. Inspectors reported that more work was still needed to improve the quality of ACCT case management.
21. Inspectors reported that investigations into incidents of violence were generally timely and of good quality and that challenge, support and intervention plans (CSIP) were used reasonably well to support victims.

### Independent Monitoring Board

22. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to April 2023, the IMB reported that they had observed healthy respect and interaction between prisoners and staff. They reported that prisoners had a laptop computer and could access limited online information, contact internal departments, select meals and place orders for goods from the prison shop. They noted this had been positive for prisoners' wellbeing.

### Previous deaths at HMP Stoke Heath

23. Mr Follos was the third prisoner to take his life at Stoke Heath since January 2021. We identified deficiencies in the delivery of ACCT at Stoke Heath in our previous investigations into the self-inflicted deaths of men at the prison in December 2021 and September 2022. There have also been four deaths from natural causes at the prison in the three years before Mr Follos' death.

## Assessment, Care in Custody and Teamwork

24. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide and 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. 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 multidisciplinary review meetings involving the prisoner.
25. As part of the process, a care plan (plan of care, support, and intervention) is put in place. The ACCT plan should not be closed until all the actions of the care-map have been completed. 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.

## Postvention procedures

26. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to supporting staff and prisoners following all deaths in custody. Postvention procedures should be initiated immediately after every self-inflicted death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners (prisoners trained by the Samaritans to provide confidential peer support) to identify the prisoners potentially most affected by a death.

## Key Events

### Background

27. Mr Simon Follos had served numerous custodial sentences. He had been diagnosed with paranoid schizophrenia, emotionally unstable personality disorder, schizoaffective disorder and drug-induced psychosis. He had been sectioned under the Mental Health Act and treated in several mental health hospitals.
28. Mr Follos also had a significant history of self-harm and substance misuse, and he struggled to cope in prison. Since 2012, his prison records noted that he heard voices telling him to kill himself. He was frequently monitored under suicide and self-harm monitoring procedures, known as ACCT. His prison records noted that he had both assaulted staff and prisoners and been the victim of bullying from prisoners, likely due to his challenging and unpredictable behaviour.
29. In February 2022, following release from a mental health hospital, Mr Follos told the police he felt psychotic. He said he had a knife and feared for other people's safety. Mr Follos said his actions were a "cry for help" as he wanted to be sectioned.
30. On 21 February 2022, Mr Follos was remanded into custody at HMP Birmingham for possession of a blade and breach of a suspended sentence. In September, he was sentenced to four months in prison, suspended for two years. In December, he was admitted to a psychiatric intensive care unit. He was discharged in March 2023.
31. On 26 March 2023, Mr Follos went to hospital and asked to be sectioned under the Mental Health Act. However, he was assessed as having mental capacity and was deemed suitable for home treatment.
32. On 27 March, Mr Follos telephoned the police. He told them that he was psychotic, had recently been discharged from a mental health hospital, had a broken glass bottle and was thinking of hurting someone as he was struggling to cope. Mr Follos was arrested for possession of an offensive weapon.

### HMP Birmingham

33. On 28 March 2023, Mr Follos was remanded to HMP Birmingham. He said he did not intend to hurt anyone but preferred prison as he "didn't survive outside".
34. On 6 April, Mr Follos wrote to his community offender manager (COM). Mr Follos said his actions had been a "cry for help" and he had intentionally been arrested to get help as the hospital had failed to help him. Mr Follos said he felt he posed more of a risk to himself than others and just wanted to be heard.
35. On 18 April, Mr Follos told staff he was hearing voices. Staff started ACCT monitoring. Concern about the effectiveness of his antipsychotic medication was listed as a trigger. Three days later, Mr Follos harmed himself by putting a plastic bag over his head and swallowing a vape capsule. He said he had done this to be moved to the prison's healthcare unit. He denied being threatened or in debt and said he felt better supported in prison.

36. On 8 May, Mr Folloos tied his television aerial around his neck. He said voices had told him to do it. He said his depot injections of paliperidone (an antipsychotic used to treat schizophrenia) were becoming less effective. Staff noted that his cell was untidy which appeared normal for him. Four days later, Mr Folloos tied a telephone cable around his neck. He told staff to remove his telephone and trainers from his cell to prevent him harming himself. Over the following days, Mr Folloos consistently misused his emergency cell bell and disrupted the wing regime.
37. On 18 May, Mr Folloos was sentenced to ten months in prison. It was noted that he was more settled knowing that he was soon to be released from prison.
38. On 26 May, Mr Folloos' ACCT was closed. He was noted to be in high spirits and had apologised for his recent behaviour. Mr Folloos said that he felt his medication was working and his mental health had improved. Mr Folloos said he was looking forward to being transferred to another prison and to his release.

## **HMP Stoke Heath**

39. On 30 May, Mr Folloos was transferred to HMP Stoke Heath. At an initial health screen, a nurse noted Mr Folloos' mental health history, that he had been given his depot injection and noted his other prescribed medications. Mr Folloos denied thoughts of suicide and self-harm. An officer noted his history of ACCT monitoring. Mr Folloos was given a single cell as his risk to others was considered high.
40. On 2 June, a mental health nurse assessed Mr Folloos. He noted his mental health, substance misuse and self-harm history. He noted that Mr Folloos' communication was unpredictable. The nurse referred him to the prison's psychiatrist and created a care plan which included monitoring Mr Folloos weekly in case he needed changes to his care plan.
41. On 5 June, a recovery worker from the substance misuse team spoke to Mr Folloos. Mr Folloos said that his substance misuse worsened his mental health, and his goal was abstinence.
42. On 9 June, a psychiatrist and a mental health nurse reviewed Mr Folloos. He told them he had hallucinated and heard voices since he was nineteen and found it difficult to sleep. Mr Folloos told them he felt most stable on paliperidone. Mr Folloos said he was hopeful for the future as he had plans for his release. He denied thoughts of suicide and self-harm. The psychiatrist noted that there would be no change to Mr Folloos' medication.
43. That day, Mr Folloos was moved to A wing, a standard wing. He applied for education and was told that pre-release support would be available.
44. On 15 June, Mr Folloos told a mental health nurse that voices in his head had told him to kill himself, that the psychiatrist had done nothing to help him and that he wanted to be sectioned. The nurse told him that he would discuss his case with the psychiatrist.
45. On 20 June, a Supervising Officer (SO) noted that concerns had been raised about Mr Folloos' mental health after he had been sexually inappropriate in front of an

officer. Mr Folloos told staff that his behaviour was a result of his mental health and that he had been smoking a teabag. Staff noted that it smelt like an illicit substance.

46. The SO told the investigator that Mr Folloos' behaviour on A wing was "quite bizarre" and became more so over time but sometimes, he laughed and joked with staff, appeared comfortable and apologised after inappropriate behaviour. She said there was no indication that Mr Folloos was being bullied. She said that the mental health nurse told her that Mr Folloos' behaviour changed when he was due his depot injection or used illicit substances. She noted that staff should remain vigilant around Mr Folloos, challenge inappropriate behaviour and issue him with incentives warnings (a method for rewarding good behaviour by allowing additional privileges, which can be removed or reduced for poor behaviour), when appropriate.
47. That day, the mental health nurse reviewed Mr Folloos. He noted that Mr Folloos appeared calmer, blamed his recent behaviour on his mental health and that he had accidentally smoked an illicit substance. (The nurse noted that Mr Folloos' medical records indicated that when he had previously taken substances, his behaviour had become more unpredictable and violent.) He noted Mr Folloos displayed no signs of psychosis.
48. On 21 June, Mr Folloos was given two incentives warnings for not attending his art class and for vaping in a communal area. The SO downgraded his incentives level to basic (one result of which was the removal of Mr Folloos' in-cell television). It was noted that over the following days, Mr Folloos was disruptive, spoke inappropriately to staff, ignored instructions, had tried to annoy other prisoners, and had misused his emergency cell bell.
49. Officers told the mental health nurse that Mr Folloos' behaviour continued to be inappropriate. The nurse noted that he had been told that Mr Folloos had defecated himself and had called officers paedophiles. The nurse noted that it was possible that Mr Folloos' depot injection had not been holding him for four weeks.
50. On 26 June, Mr Folloos sent an application to the Offender Management Unit (OMU) asking for a new cell key as prisoners were stealing from his cell when he was not there.
51. Mr Folloos was given an incentives warning for making inappropriate comments. He also told staff that he had urinated himself, but it was later established that he had not. The mental health nurse told staff that they might see a change in Mr Folloos' behaviour after he had received his depot injection. (Mr Folloos was given his depot injection on 28 June.)
52. Later that morning, Mr Folloos told the mental health nurse that he was struggling, that officers were picking on him and he had been told that everything he did was a behavioural concern. The nurse noted that Mr Folloos appeared calm and apologised for his behaviour.
53. That afternoon, an officer used minimal force to restrain Mr Folloos after he was verbally aggressive and threatening. The following day, Mr Folloos apologised for his behaviour which he said was because he had heard voices. The officer said staff did not know "which version" of Mr Folloos they would get when they opened his cell door.

54. On 27 June, the SO carried out an incentives review for Mr Follo due to his poor behaviour. He remained on the basic regime. The following day, Mr Follo continued to misuse his cell bell but settled over the following days.
55. On 30 June, Mr Follo applied to speak to someone from safer custody as he said he had been attacked three times and nothing had been done.
56. On 3 July, Mr Follo was told that a member of staff would complete a welfare check and he would be asked to give a statement so the matter (the alleged attacks) could be investigated. An officer, who completed the check, noted that Mr Follo had said he felt fine and wanted to know when he would get his television back. The officer told him that he would be allowed a television when his behaviour improved.
57. That day, a prisoner offender manager (POM) met Mr Follo to discuss his post-release accommodation plans as he was due for release on 25 August.
58. On 4 July, Mr Follo told the mental health nurse that his depot injection was working. The nurse noted that although Mr Follo presented with some delusion, it was minimal compared to previous weeks.
59. On 6 July, a worker from OMU noted that Mr Follo had ordered a copy of his birth certificate which he would need when released.
60. On 10 July, Mr Follo's incentives level was raised to standard following a period of good behaviour.
61. That day, Mr Follo made an application to a SO for a transfer to another prison as he said he did not feel safe at Stoke Heath. Mr Follo also told chaplaincy and safer custody staff that he did not feel safe at the prison after telling other prisoners that he was a paedophile.
62. On 11 July, during a welfare check, Mr Follo told an officer that he felt "unsteady" on the wing after he had told prisoners that he was a paedophile. Mr Follo declined to have a separate regime from other prisoners. (The chaplaincy staff also told Mr Follo to contact OMU. The SO responded and told Mr Follo to write his concerns on a witness statement.)
63. On 12 July, Mr Follo was given his post-sentence supervision order and licence conditions in preparation for his release.
64. On 13 July, Mr Follo made a further application for a prison transfer and asked if his community support worker had been contacted.
65. On 15 July, during a welfare check, Mr Follo told an officer that he was okay on the wing, wanted to stay out of trouble and keep to himself. The officer noted Mr Follo's positive attitude.
66. On 18 July, Mr Follo told the mental health nurse that he was struggling, he was increasingly confused and paranoid that prisoners on the wing were talking about him and calling him a paedophile. The nurse reminded Mr Follo that this was likely because he had told them that. He planned to see Mr Follo again when he returned from leave.

67. On 19 July, Mr Follos made an application to healthcare. He said he had swallowed a razor the previous week. He asked for and was prescribed sleeping tablets.
68. On 20 July, an officer completed a key work session. He noted that Mr Follos had said he was okay but wanted to keep to himself and not mix with other prisoners. Mr Follos declined the officer's offer to help prepare for his release.
69. That day, Mr Follos made an application to the safer custody team to say he had been attacked in his cell and did not feel safe on the wing. On 24 July, the safer custody team responded that they were looking into his concerns and a welfare check would be completed. (There is nothing in Mr Follos' prison record, or other wing records about him being attacked.)
70. That afternoon, an officer held another key work session with Mr Follos. Mr Follos said he did not need anything in preparation for his release and wanted to keep his head down until then. The officer noted that he ended the session as Mr Follos appeared bored and wanted to return to his cell.
71. The officer told the investigator that he was concerned about Mr Follos' hygiene and had to tell him to shower and clean his cell.
72. On 26 July, the psychiatrist reviewed and renewed Mr Follos' depot prescription.
73. On 28 July, Mr Follos made an application to the mental health team to say he could not sleep for more than two hours a night and felt depressed.
74. On 31 July, Mr Follos told staff he felt low, and he was given time to talk to a Listener (a prisoner trained by the Samaritans to provide a listening service). He said talking to the Listener helped and he denied thoughts of self-harm.
75. On 3 August, a SO downgraded Mr Follos' incentives status to basic after he misused his cell bell. She noted that Mr Follos had asked for vapes which was not considered an emergency.
76. On 5 August, Mr Follos told staff that voices had told him to kill himself, that he had wanted to die and had recently drunk the contents of a vape capsule. Staff started suicide and self-harm prevention procedures, monitoring him hourly. A mental health nurse saw Mr Follos and referred him to the mental health team. He declined to speak to a Listener or the Samaritans. He told staff he wanted to stay on A wing and would probably "snap out of it".
77. On 6 August, an officer completed an ACCT assessment. He noted Mr Follos struggled with his mental health and had been given vapes to calm down.
78. A SO chaired an ACCT review. A nurse from the mental health team attended. The SO noted that Mr Follos appeared positive and spoke about his future but said he had not slept, felt stressed and struggled with hearing voices. Mr Follos denied thoughts of self-harm. Staff considered that Mr Follos' risk of self-harm was low, and his observations were lowered to five a day. The nurse referred Mr Follos to the mental health team to discuss his medication. It was noted that Mr Follos was grateful for the referral as he wanted to stabilise his mental health before release. That afternoon, Mr Follos spoke to a Listener, appeared in a better mood, and socialised with other prisoners.

79. On 7 August, an officer completed a keywork session. Mr Follo told the officer that he did not need any support in preparation for his release.
80. That day, Mr Follo made an application to the chaplaincy team. He asked to be baptised a Catholic and wanted an exorcism, as he was possessed by an evil spirit.
81. On 8 August, Mr Follo told an officer at a keywork session that he was going to join a prisoner-led support group for prisoners with mental health issues. The officer noted that Mr Follo did not appear to take care of himself and gave him cleaning products. Mr Follo told the officer he still heard voices but denied thoughts of suicide or self-harm.
82. That day, a SO chaired an ACCT review. The officer attended. A nurse gave the SO a healthcare update beforehand. She told the SO that the mental health team was due to see Mr Follo the next day. The SO noted that Mr Follo engaged well, said he was doing "alright" and found talking to Listeners and the Samaritans useful. The SO reminded Mr Follo about his meeting with the mental health team and noted that Mr Follo had said that there was nothing further staff could do to support him, but he found it helpful to talk. The SO considered Mr Follo posed a low risk of suicide and self-harm, and as there were no further caremap actions to be completed, she closed the ACCT. That afternoon, it was noted that Mr Follo collected his meal and appeared "in excellent spirits".
83. On 9 August, Mr Follo told a nurse that he had harmed himself the previous weekend because he had felt low. He said he just wanted to get on with things before his release and denied thoughts of suicide and self-harm. The nurse noted that arrangements for a community mental health team referral would be made pending his release.
84. On 9 August, a SO noted, following an incentives review, that Mr Follo would remain on the basic regime for continually misusing his cell bell. He later noted that Mr Follo had engaged positively with other prisoners who had helped him complete pre-release forms.
85. During the evening routine roll check on 11 August, Mr Follo told an Operational Support Grade (OSG) that he had swallowed a pen as he felt fed up. Staff restarted ACCT monitoring and agreed to observe him hourly.
86. A Custodial Manager (CM) completed an ACCT review. He noted that Mr Follo displayed no symptoms after allegedly swallowing a pen and had no difficulty breathing. Mr Follo said he was bored and was due for release in thirteen days. The CM told him that he would be monitored overnight and would be referred to the healthcare team. Other items that Mr Follo might swallow were removed from his cell.
87. On 12 August, Mr Follo had a prison X-ray body scan (in response to having swallowed a pen). Nothing was detected and a CM noted that Mr Follo could not explain why. Healthcare staff assessed Mr Follo, took observations but noted no further concerns.
88. That afternoon, a CM chaired an ACCT case review. Healthcare staff gave an update beforehand. He noted that healthcare staff had found no evidence that Mr

Follos had swallowed a pen. Mr Follos told the CM he was stressed about his impending release but had no thoughts of suicide or self-harm. The CM discussed with Mr Follos his accommodation on release and assured him that it would be arranged. He noted that the mental health nurse would see Mr Follos on 15 August, and this boosted Mr Follos' mood. He concluded that Mr Follos was upbeat, not in crisis and denied thoughts of suicide and self-harm. He concluded that the ACCT could be closed.

89. On 15 August, Mr Follos told the mental health nurse that he only managed to sleep for two to three hours a night. The nurse noted that Mr Follos appeared unkempt but did not look tired. Mr Follos asked him if the psychiatrist could give him sleep medication. The nurse told Mr Follos that the psychiatrist was not at the prison for two weeks and could therefore not review his medication before his release. He noted that Mr Follos accepted this, was looking forward to his release and was determined not to return to prison. Mr Follos provided his release address, which was in supported housing. The nurse told him that he would refer him to the community mental health team who would take over his mental healthcare.
90. That day, Mr Follos contacted a SO and told him his release address had been approved. Mr Follos was moved to C wing. There is nothing to explain why he was moved.
91. On 16 August, a worker from the prison's substance misuse team tried to speak to Mr Follos but was unable to due to an incident on the wing.
92. A member of staff from OMU sent details of Mr Follos' licence and release address to his COM. The following day, healthcare staff sent a summary of Mr Follos' healthcare needs to his local GP surgery. Mr Follos' incentives level was raised to standard due to an improvement in his behaviour.
93. On 18 August, a CM completed Mr Follos' post-closure ACCT review. Mr Follos told him that he enjoyed being on C wing as people left him alone. Mr Follos said that when he felt low, he felt "not worthy" and a "piece of shit", but he was trying to have a positive mindset and would speak to staff if he felt low. The CM **decided the ACCT could remain closed** as Mr Follos' mindset had been positive.

## Events of Sunday 20 August

94. At 7.30pm on 20 August, Mr Follos told an officer that he had swallowed a key. Staff restarted ACCT procedures. A CM, who was temporarily undertaking the role, chaired an ACCT case review. Mr Follos said he was fed up of hearing voices, felt low and did not know what to do. Mr Follos asked the CM to move him to the segregation unit. (The CM said Mr Follos was fixated on this.) The CM told him that the segregation unit was not the safest or most appropriate place for him and there was more support on the wing. Mr Follos asked staff to remove his television, laptop and other items from his cell to prevent self-harm. The CM told Mr Follos that he could speak to the mental health team the next day. He noted that Mr Follos was concerned about his release the following week. He explained to Mr Follos that staff would be available to help him the following morning. He noted this in the ACCT so that staff could pick it up the next day. He said that Mr Follos reassured him that he would not do anything overnight, and he concluded that Mr Follos should be observed hourly until his next review the following morning.

95. At around 8.21pm, an officer spoke to Mr Follo at his cell door. Mr Follo told the officer he had swallowed stuffing from his pillow and did not want to live anymore. Staff removed the pillow from Mr Follo. At 8.57pm, the officer carried out a check and noted that Mr Follo was lying on his bed, fully clothed.

## Events of 21 August

96. Mr Follo told an officer that he had wet his bed during the night. The officer said he took the comment at face value but on closer inspection, it looked as if Mr Follo had poured a cup of water on himself. At around 8.40am, the officer noted that Mr Follo had been given clean clothing, bedding and cleaning products for his cell. That morning, Mr Follo mixed with other prisoners.
97. At 10.00am, a CM chaired an ACCT review which the mental health nurse attended. Prior to the review, Mr Follo had been cleaning his cell. The CM said he read a CM's review from the previous evening. Mr Follo told the CM that he struggled with voices in his head which did not stop, and he wanted to be left in peace. In response to the CM's questions, Mr Follo said he did not know what had changed since the ACCT had been closed on 18 August, but he wished he did not have mental health issues.
98. The mental health nurse said that Mr Follo looked tired, anxious and low, but Mr Follo denied this and said he was looking forward to his release. Mr Follo told the nurse that he did not think his medication worked and he wanted to see the psychiatrist again. The nurse told Mr Follo to raise any concerns with the community mental health team on release.
99. Mr Follo was concerned that he might be sectioned on release. He was reassured that this would not happen. Mr Follo then said he wanted to be sectioned as he had committed an offence so that he could be taken into custody to get help. The mental health nurse told Mr Follo that on release, he could voluntarily section himself, but the community mental health team would ultimately decide. The nurse told Mr Follo that his community mental health referral had been completed.
100. Mr Follo told the CM that he had no thoughts of suicide or self-harm and wanted to continue cleaning his cell. The CM and the mental health nurse concluded that Mr Follo should remain on ACCT monitoring until his release, but they agreed to reduce his observations to five times a day. A further review was scheduled for 23 August, two days before Mr Follo's planned release.
101. At 10.52am, OMU sent Mr Follo a message to confirm that post-release accommodation had been found and he should attend his probation appointment on release. At 2.41pm, Mr Follo responded, "okay thanks".
102. That morning, a worker from the substance misuse team went to see Mr Follo to discuss the risks of substance misuse in preparation for his release. He later noted that he had not been able to do so as Mr Follo had appeared angry or upset and was in an "animated conversation" with an officer. He said Mr Follo was "talking forcefully". (We have not been able to identify this officer or any further details about the nature of the exchange.) He considered that there was no point trying to speak to Mr Follo afterwards and planned to see him again after his depot injection.

103. The worker told the investigator that he spoke to the mental health nurse about Mr Follos' presentation. He said that the nurse told him that Mr Follos was due his depot injection and his mental health deteriorated in the period leading to it. (Mr Follos received his depot injections at the end of each month.)
104. At 3.45pm, a nurse noted that Mr Follos had attended the medication hatch and told healthcare staff that he had swallowed a vape and burnt his left hand which was noted as red but with no blistering. She noted in the ACCT record that she would hand over to the evening duty nurse and wing staff. (There is no entry in Mr Follos' medical records or in other prison records to confirm if this happened.)
105. Staff completed Mr Follos' ACCT checks that evening and an officer noted that Mr Follos raised no concerns.

## Events of 22 August

106. On the night of 21 to 22 August, staff checked on Mr Follos in line with his ACCT observations but noted no concerns.
107. At 7.45am on 22 August, Mr Follos' cell was unlocked, and he left to exercise outside before Officer A locked him back in his cell. At 8.24am, Officer B spoke to Mr Follos at his cell door. He could not recall their conversation, but said it was most likely that Mr Follos had asked for vapes.
108. At 9.13am, Officer B unlocked Mr Follos. He left his cell and on several occasions over the following few hours, left and returned to his cell and interacted briefly with other prisoners. During some of this time, Mr Follos squatted on the floor outside his cell, vaping, and watched another prisoner have a haircut. At 10.50am, Mr Follos was locked in his cell.
109. At 11.29am, Officer B unlocked Mr Follos to collect his lunch. The officer locked him back in his cell at 11.34am.
110. At 11.49am, Officer A answered Mr Follos' cell bell. He said that when he opened the cell door, Mr Follos told him he felt like smashing his laptop and asked him to take it away. He said that when he took the laptop, Mr Follos told him to take his trainers too. He said he did not recall asking Mr Follos why he wanted to damage the laptop or why he wanted the items removed because it was not the first time he had asked staff to remove items from his cell.
111. Officer A said that Mr Follos had said he felt tired. The officer suggested he should sleep. He said that Mr Follos had not appeared distressed.
112. At 11.53am, Officer A completed the roll check. He said that Mr Follos was lying on his bed. At 11.55am, Officer B completed an ACCT check on Mr Follos. This was the last time Mr Follos was seen alive.
113. At 4.30pm, Officer B unlocked Mr Follos' cell so he could collect his evening meal. He turned to walk away from the cell but returned within seconds as he felt something was not right and went into the cell. He found Mr Follos at the back of the cell, in a seated position below the window, with a ligature made out of a sheet around his neck and tied to the window. (He said the ligature did not need to be cut.)

He described it as like a loop of fabric which Mr Folloos had sunk into.) He radioed a general alarm and a prisoner passing by on the landing also pressed the alarm. Seconds later, he radioed a medical emergency code blue (indicating a prisoner is unconscious or having trouble breathing) and an ambulance was called at 4.31pm.

114. Two prisoners helped Officer B lift Mr Folloos from the ligature as Officer C arrived. Officer B checked for signs of life but found none. He started CPR. Officer C and other officers who attended took over resuscitation efforts. Healthcare staff arrived at 4.34pm with their emergency response bags. Mr Folloos was moved onto the landing and healthcare staff took the lead in resuscitation attempts. A defibrillator was attached but advised no shock. At 4.55pm, paramedics arrived, assessed Mr Folloos and continued CPR. At 5.03pm, an air ambulance doctor declared that Mr Folloos had died.

### **Contact with Mr Folloos' family**

115. Despite the significant efforts of the prison, police and other services to contact Mr Folloos' next of kin, it was not until the evening of 29 August – a week after Mr Folloos' death - that West Midlands Police broke the news of his death to his sister. The following day, the family liaison officer contacted Mr Folloos' sister and later visited her. Mr Folloos' sister told her that she had received a letter from Mr Folloos a few days before his death. She said he had asked her to send him her telephone number and some money, he had said he did not feel very well, and his medication did not suit him. But he also said he was looking forward to his release, planned to go to Alcoholics Anonymous meetings and to look for charity work.
116. Stoke Heath contributed more than the recommended amount outlined in national instructions towards funeral expenses. The prison's chaplaincy helped Mr Folloos' sister organise his funeral and provided additional support.

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

117. Stoke Heath initiated postvention procedures. After Mr Folloos' death, the Governor debriefed the staff involved in the incident to ensure they had the opportunity to discuss any issues arising, and to offer support. The care team also offered support.
118. The prison posted notices informing other prisoners of Mr Folloos' death and offered support. The prison also used Listeners to offer support on the wing. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Folloos' death.

### **Information provided to IMB and PPO after Mr Folloos' death**

119. After Mr Folloos' death, prisoners made allegations to the IMB and PPO about staff and prisoners mistreating Mr Folloos, and engaging in unprofessional behaviour, at Stoke Heath. The PPO interviewed three prisoners about these allegations.
120. One of the prisoners who made some of the allegations had transferred to another prison. That prisoner had shared his concerns with prison staff who then submitted

intelligence reports. Stoke Heath told us that they did not take any action or conduct an investigation, as the intelligence reports did not contain dates or staff names.

### **Post-mortem report**

121. A post-mortem examination found that Mr Follos died from hanging. The post-mortem report highlighted that Mr Follos had a number of objects in his stomach and rectum, including a Chubb key, two scrunched up plastic bags and thin pieces of plastic/metal which may have been vape cartridges.
122. Toxicology tests confirmed no evidence of recent synthetic cannabinoid use. However, a number of other substances, including promethazine (which was prescribed) and citalopram, diazepam and amphetamine (which were not prescribed) were identified at low levels. The pathologist concluded that these were unlikely to have contributed to Mr Follos' death.

## Findings

### Management of risk of suicide and self-harm

123. In line with Prison Service Instruction (PSI) 64/2011 on safer custody, which was in place at the time of Mr Follos' death, staff appropriately started ACCT monitoring on 5 August 2023, after Mr Follos told them he had drunk the contents of a vape capsule and had heard voices telling him to kill himself. Mr Follos' ACCT monitoring was closed on 8 August but reopened for a day on 11 August, after Mr Follos told staff he had swallowed a pen. Staff restarted ACCT monitoring on 20 August, after Mr Follos said he had swallowed a key and was fed up with hearing voices.
124. However, we are concerned that the ACCT procedures were not always started when they should have been, they were poorly managed, did little to support Mr Follos or address his underlying issues and were closed prematurely.

### Failure to start ACCT monitoring

125. On 15 June, when Mr Follos told the mental health nurse that voices had told him to kill himself, the nurse should have opened an ACCT. The nurse said he did not do so as he felt Mr Follos was saying it more than thinking it. He told us he had not received ACCT training but if he had genuinely thought Mr Follos would harm himself, he would have opened an ACCT. While this may be the case, the PSI was clear that staff should begin ACCT procedures if a prisoner disclosed thoughts of suicide or self-harm. This was a missed opportunity to identify any increasing risk factors for Mr Follos and address them early through an ACCT assessment and review.
126. Following a scheduled ACCT review on 21 August, Mr Follos told a nurse that he had swallowed a vape pen and had burnt his hand. The nurse recorded details in the ACCT, but it is not clear if she took any other steps to inform prison staff or healthcare colleagues. Staff should have held an ad hoc case review in line with PSI 64/2011 to re-assess his immediate risk. This was another missed opportunity to assess Mr Follos' risk and to consider introducing protective measures such as increasing the frequency of his observations and arranging an urgent mental health review.

### Frequency of ACCT observations

127. At the ACCT review on 21 August, the day before he died, Mr Follos denied thoughts of suicide and self-harm and said he was looking forward to his release. However, he had also told them at that review and the ad hoc review the previous day, that he continued to struggle with voices in his head, did not think his medication was working and wanted to see a psychiatrist. The mental health nurse also noted that he appeared tired, anxious and low - which he denied. At the ad hoc review on 20 August, Mr Follos had also said that he was concerned about his release and that day had said he had harmed himself by swallowing stuffing from his pillow. Staff at the ACCT review concluded that the frequency of observations could reduce from hourly to five observations during the day and night.

128. We consider that the reduction in frequency of ACCT checks was premature given the unpredictability of Mr Follos' behaviour and demeanour. He was due a depot injection and staff recognised that his behaviour was more difficult in the days before his next dose of antipsychotic medication. The frequency of ACCT observations on the day Mr Follos hanged himself did not adequately reflect his level of risk, and we do not consider that the risks identified in the reviews on 20 and 21 August were sufficiently addressed before staff lowered the frequency of observations.
129. We are also concerned that on 22 August, the day Mr Follos died, staff completed all five of the required ACCT observations between 7.00am and 11.55am. They did not check on him again until 4.30pm, when they unlocked his cell for his evening meal and found him hanged. While we accept that the five ACCT checks were completed, they were not evenly distributed throughout the day but were completed within a five-hour window in the morning. A CM agreed that the expectation could have been made clearer to staff that they should have spread the observations more evenly through the day to keep Mr Follos safe.

### **Use of the ACCT care plan to inform decisions**

130. On two occasions, staff closed ACCT procedures prematurely before all the care plan actions had been completed. On 8 August, Mr Follos' ACCT was closed despite him telling an officer that day that he still heard voices and an action for the mental health team to assess him remaining outstanding. In interview, a SO said she stood by her decision to close the ACCT given that Mr Follos was already under the care of the mental health team, was not new to prison and, from her experience of working with him, was not at a point of crisis.
131. A nurse, who had referred Mr Follos to the mental health team on 6 August, said she would have expected the ACCT to have remained open until the mental health assessment had been completed. We agree.
132. On 12 August, a CM closed Mr Follos' ACCT, even though he had told staff he had swallowed a pen the previous evening and had said that he was stressed about his accommodation on release. Although the CM noted that he had assured Mr Follos that his accommodation would be arranged, the ACCT should not have been closed but instead, his care plan should have been updated to reflect Mr Follos' concerns about his release so that his offender manager could address these.
133. On 20 August, Mr Follos told staff he had swallowed a key as he was fed up with hearing voices and was concerned about his release. Staff restarted ACCT monitoring and at an ACCT review, a CM told Mr Follos that he could speak to the mental health team the following day and staff would address his concerns about release. Again, neither action was noted on Mr Follos' care plan, and staff therefore did not address them the following day. The CM acknowledged that he should have done this. We also note that the care plan did not include reference to Mr Follos eating the stuffing from his pillow.
134. We are also concerned that a CM had not properly considered the importance of the previous entries and reviews in Mr Follos' ACCT on 21 August. He made no further additions to the care plan.

135. Guidance in the ACCT document notes that staff should not end ACCT procedures if there are any outstanding issues. We consider that staff did not recognise that actions on Mr Follos' care plan had not been completed or that new actions should have been added and addressed.

We identified similar deficiencies in ACCT procedures in our investigations into the self-inflicted deaths of men at Stoke Heath in December 2021 and September 2022. HMIP also identified that more work was needed to improve the quality of ACCT case management. Although Stoke Heath agreed to implement our previous recommendations, it is clear from the failings in this case that more needs to be done to embed the necessary learning. We therefore make the following recommendations:

**The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with the Prison Safety Policy Framework, including that stringent ACCT quality assurance procedures are in place for senior managers to identify poor practice, learn lessons and, where appropriate, provide staff with refresher training.**

**The Prison Group Director for West Midlands should outline in the action plan for this report the steps she has taken to satisfy herself that effective action is being taken to improve ACCT quality assurance at Stoke Heath.**

### **Mr Follos' concerns for his safety**

136. PSI 64/2011 set out how violent prisoners should be managed. It said that victims should be supported and protected. Being a victim of intimidation or violence are recognised risk factors for suicide and self-harm. The PPO has published a range of publications identifying the links between bullying and suicide and we identified the need for staff to record and investigate all reports or suspicions that a prisoner is being threatened or bullied and to consider the potential impact on the victim's risk of suicide.
137. On five occasions between 26 June and 20 July, Mr Follos told staff that he feared for his safety and reported being attacked multiple times and having items stolen from his cell. Staff recorded just three welfare checks during this period, and there is no evidence that they took any specific action or investigated his concerns appropriately.
138. Stoke Heath's safer custody policy requires that the prison's violence reduction or safety team investigates allegations of bullying as soon as possible and that they should produce a report outlining recommendations and next steps which may include monitoring perpetrators, a referral to offending behaviour programmes and the creation of a Challenge Support Intervention Plan (CSIP) for victims. (A CSIP is a multidisciplinary approach which focuses on prisoners at raised risk of being violent and works to change their behaviour.) There is no evidence that staff took any meaningful action to investigate and address Mr Follos' concerns and there is little evidence that interventions were implemented to help him feel less scared.
139. It is not acceptable for any prisoner to feel unsafe. The Governor must ensure that staff understand their responsibilities, and the policies and processes in place to

challenge, investigate and escalate inappropriate behaviour by prisoners to one another. We recognise the complexities in identifying and investigating alleged inappropriate behaviour and the difficulties staff face in investigating unevidenced or unspecified fears that a prisoner is under threat. However, it is possible that Mr Follos' experiences might have contributed to his feelings of hopelessness. We make the following recommendation:

**The Governor should ensure that staff:**

- **fully and promptly investigate information about bullying and intimidation;**
- **challenge alleged perpetrators appropriately; and**
- **support victims effectively and properly consider and address the possible impact on their risk of suicide and self-harm.**

## **Allegations about staff behaviour towards Mr Follos**

140. After Mr Follos' death, several prisoners alleged to the PPO and IMB that staff and prisoners had mistreated Mr Follos. The investigator interviewed fifteen members of staff, including three whom allegations had been made against. The three officers we interviewed about the allegations denied the behaviours alleged and they and other officers told us that they felt confident reporting inappropriate behaviours towards prisoners if they saw it.
141. In relation to some of the allegations, we have evidence to help us understand whether they demonstrated that Mr Follos was being treated differently or unfairly by staff (for example, losing his access to in-cell television through misuse of his cell bell). However, we have not been able to establish whether other of the allegations were true, and if they were, whether they contributed to Mr Follos' decision to take his life.
142. They were of sufficient gravity that we raised them with the Governor. The investigator and an Assistant Ombudsman at the PPO met the Governor remotely on Teams twice between January and April 2024 to discuss in detail the allegations made, concerns about staff conduct and the action he had taken and planned to take.
143. HMPPS' Tackling Unacceptable Behaviours Unit completed a climate assessment report about Stoke Heath in April 2023. The Governor told the PPO that this had been commissioned before he had arrived at Stoke Heath. The Governor reported that most of the feedback from the assessment was about the prison's senior leadership team, equity of opportunities and staff culture. The Governor told us that five new senior managers had taken up roles, including a new Head of Security and Head of Residence.
144. The Governor told the PPO that Stoke Heath was safe and that a safety report from the Operational and System Assurance Group, published in December 2023, had given the prison an amber/green rating (indicating a generally positive assessment). The Governor said that the HMIP report of 2023 had also given the prison a rating of four out of five for safety and three out of five for respect. He said that the data on

assaults and self-harm were significantly below the level for comparator prisons. However, the Governor acknowledged that there may be pockets of staff who acted illegitimately. He said he continued to make changes at Stoke Heath and, for example, had changed incentives guidance to make the system fairer.

145. The Governor confirmed that one of the officers whom prisoners alleged had acted inappropriately was dismissed for failing his probation. He told us that another officer against whom allegations were made had also been dismissed on matters unrelated to these allegations. The Governor told us that he had considered the allegations we passed to him but considered that there was no other evidence to warrant investigations into the other five officers identified. He said that he tackles staff issues robustly when he has sufficient evidence to do so.
146. The Governor said that since his arrival at Stoke Heath in summer 2023, he had dismissed eight members of staff for conduct-related issues and admitted that Stoke Heath had challenges. He said he was committed to Stoke Heath being progressive and rehabilitative and to rooting out bad behaviours.
147. On 5 August 2024, the PPO wrote to the Governor seeking further assurances that the allegations about staff's behaviour towards Mr Follos did not indicate a systemic issue at Stoke Heath.
148. The Governor shared with us a summary of the climate assessment report which had previously been shared with prison staff, and complaints data for the quarter leading to Mr Follos' death and the most recent completed quarter (which was to August 2024).
149. The climate assessment summary reported that 24% of staff who had completed the survey had been subject to bullying, harassment or discrimination, and a further 40% had witnessed such behaviours. The summary highlighted the perception that the senior leadership team were most actively involved in behaviours considered to be unacceptable. It also indicated concerns about attitudes, unacceptable behaviours and comments about protected characteristics.
150. The complaints data provided indicated a similar number of complaints about staff in 2023 and 2024. It did not provide sufficient detail for us to establish whether there are systemic issues about staff misconduct at Stoke Heath, as raised in the allegations made by prisoners – and in any case, we know that prisoners are often reluctant to make complaints about staff behaviour for fear of repercussions.
151. The Governor assured us that he had implemented changes to keep Stoke Heath safe and that he takes staff conduct and prisoner safety seriously. Given the number of allegations about staff behaviour made after Mr Follos' death, and his own concerns for his safety, we consider this to be an issue requiring continued focus at Stoke Heath. We expect Governor Greenhaf to continue his efforts to prioritise safety and respect at the prison, and tackle staff misconduct.

## **Clinical care**

152. The clinical reviewer concluded that the healthcare that Mr Follos received in custody was of a good standard and was at least equivalent to that which he could

have expected to receive in the community. The clinical reviewer concluded that Mr Follos received care and support from mental health services at Stoke Heath.

153. However, Shropshire Community Health NHS Trust's Serious Incidents Investigation Report identified learning and made several recommendations about the delivery of mental health services which the Head of Healthcare at Stoke Heath will want to address.

### **Good practice**

154. The appointed family liaison officer and the chaplaincy team at Stoke Heath demonstrated compassion and provided comprehensive support to Mr Follos' sister after his death.

### **Inquest**

155. The inquest into Mr Follos' death was held on 10 to 14 November 2025. The jury concluded that Mr Follos died with unknown intent having self-ligated by means of a bedsheet attached to a window in his cell. It was not possible to determine what his intention was at the time that he did this.

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