Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ian Brown a prisoner at HMP Woodhill on 19 July 2015

A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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 Brown hanged himself in his cell at HMP Woodhill on 19 July 2015. He was 44 years old. I offer my condolences to Mr Brown's family and friends.

Mr Brown was a vulnerable man, with mental health issues, who had got into debt after borrowing tobacco and appeared to be being bullied as a result. I am concerned that Woodhill did not take sufficient action to investigate Mr Brown's concerns or to support him as a victim of bullying. I am also concerned that his mental health care was interrupted for some weeks before his death, apparently because of staff shortages.

Mr Brown had been on suicide and self-harm prevention procedures three times at Woodhill and the investigation found a number of areas for improvement. However, he was not subject to these procedures at the time of his death and I consider that it would have been difficult for staff to have identified that he was at imminent or particularly high risk at that time.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **April 2016**

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Summary

Events

1. On 12 January 2015, Mr Ian Brown was remanded in custody at HMP Woodhill charged with aggravated burglary and other offences. Mr Brown had depression and paranoid schizophrenia, which his GP and community mental health team were managing successfully. He had been in prison before and during two previous sentences served at Woodhill, Mr Brown was monitored under Prison Service suicide and self-harm prevention procedures (known as ACCT). He said that he had tried to hang himself three days before he arrived at Woodhill.

2. Staff monitored Mr Brown under ACCT procedures from 12 January until 20 January, and again from 8 February until 20 February. On 20 April, Mr Brown harmed himself again and staff began ACCT procedures for a third time. Mr Brown saw the prison psychiatrist and had frequent reviews with mental health nurses.

3. In May, it became clear that Mr Brown had accumulated debts from borrowing tobacco. On 30 May, prisoners stole Mr Brown's prison issue television from his cell and Mr Brown told staff that he would hang himself. He was placed on renewed monitored time and officers replaced his television.

4. On 5 June, Mr Brown told staff he was being bullied because of his tobacco debts. It is not clear whether he named the perpetrators, but officers moved him to another part of the unit. He settled well and, on 19 June, staff ended the ACCT monitoring. Mr Brown either got into debt again, or was still pursued for previous debts. However, Mr Brown made no complaints and staff were not worried about him.

5. On the morning of 19 July, two prisoners took Mr Brown's television from his cell while he was not there. Mr Brown told an officer, who said staff would resolve the issue after lunch. Shortly after, Mr Brown asked to speak to the supervising officer, but could not as she was on her lunch break. None of the officers who spoke to him that day had any concerns that his immediate risk of suicide or self-harm had increased.

6. At 1.10pm, an officer found Mr Brown had hanged himself in his cell. Staff and paramedics tried to resuscitate him, but sadly, he was pronounced dead at 1.40pm.

Findings

7. Mr Brown had a number of risk factors, which increased his risk of suicide. He was subject to ACCT monitoring on a number of occasions, and we have identified shortcomings in the management of these procedures. At the time of his death, Mr Brown was not being managed under ACCT procedures, although he was still being bullied, including having his television stolen shortly before his death. Nevertheless, we accept that officers had no particular reason to begin ACCT procedures again, or to consider that his risk of suicide had substantially increased. We do not think that they could have foreseen his actions.

8. We are concerned that, despite evidence that Mr Brown being bullied and was vulnerable, too little was done to investigate his concerns and victim support measures were inadequate.

9. We also found that, although Mr Brown initially received good support from the mental health team, he had not seen a mental health nurse for five weeks before his death, apparently because of staff shortages.

Recommendations

- The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidance, including:
    - Multi-disciplinary approach for all case reviews, in particular for review members to be present when considering closure of ACCT procedures.
    - Setting and updating specific and meaningful ACCT caremap objectives to address the underlying causes of a prisoners distress.
    - Involving the prisoner's family/next of kin when that would be beneficial.
- The Governor should ensure that all information indicating bullying and intimidation is fully investigated and that apparent victims are effectively supported and protected with meaningful solutions which address their individual situation, including through ACCT procedures where appropriate.
- The Head of Healthcare should ensure that there is a fully staffed mental health team and that mental health reviews are completed appropriately and to the required standard.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Woodhill informing them of the investigation and asking anyone with relevant information to contact him. Two prisoners responded.

11. The investigator visited HMP Woodhill on 28 July 2015. He obtained copies of relevant extracts from Mr Brown's prison and medical records.

12. NHS England commissioned a clinical reviewer to review Mr Brown's clinical care at the prison.

13. The investigator interviewed twelve members of staff and four prisoners at Woodhill between August and October. The clinical reviewer and the investigator interviewed some staff jointly.

14. We informed HM Coroner for Milton Keynes of the investigation. We have sent the coroner a copy of this report.

15. One of the Ombudsman's family liaison officers contacted Mr Brown's family, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Mr Brown's family said that Mr Brown told them he was in debt for tobacco and they wanted to know more about this, and whether he was the victim of bullying as a result. They also asked whether he took his medication as prescribed.

16. Mr Brown's family received a copy of the initial report. The solicitor representing Mr Brown's family wrote to us raising a number of questions that do not impact upon the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

Background Information

HM Prison

17. HMP Woodhill has a dual role of a local prison and high security prison and can hold more than 800 men. Central and North West London NHS Foundation Trust provide all healthcare services at the prison including mental health.

HM Inspectorate of Prisons

18. The most recent full unannounced inspection of HMP Woodhill was in January 2014. Inspectors found that the number of self-harm incidents was very high - double what they found in other local prisons - and that the quality of suicide and self-harm prevention procedures was poor. Inspectors reported that this office had identified common themes in previous deaths at the prison, but that action plans in response to these deaths needed further development. Inspectors found that, although health services were generally good, mental health provision was insufficient to meet demand.

19. Inspectors found that many prisoners said they felt victimised and that the violence reduction policy was out of date and too generic. They found that concerns raised during their previous inspection about the safety of vulnerable prisoners had not been fully addressed, but that prisoners said staff were more proactive in identifying and challenging bullying and intimidation.

20. The Inspectorate inspected Woodhill again in September 2015. Although the report has not yet been published, we understand that inspectors had significant concerns about mental health provision at the prison. They found the service to be under resourced, which had been exacerbated by significant staff recruitment problems, meaning the team did not have the capacity to adequately meet the needs of prisoners.

Independent Monitoring Board

21. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In their latest annual report, for the year to May 2015, the IMB reported that the healthcare and mental health staff continued to deliver a good service, despite being hampered by recruitment issues.

Previous deaths at HMP Woodhill

22. Mr Brown's was the ninth self-inflicted death at Woodhill since 2013. There have also been two natural cause deaths during this time. In this report and in a two previous reports, we identified deficiencies in the quality of ACCT procedures and have repeated the recommendations.

Assessment, Care in Custody and Teamwork

23. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.

24. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

25. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

26. Mr Ian Brown had been in prison several times since 2006, including at Woodhill, where he was twice monitored under ACCT procedures. He had a history of self-harm and had attempted suicide by hanging during an earlier sentence. He had been diagnosed with paranoid schizophrenia about nine years earlier, which was being successfully managed in the community by his GP and community mental health team.

27. On 10 January 2015, Northamptonshire Police arrested and charged Mr Brown with aggravated burglary with intent to commit grievous bodily harm, threats to damage property (both against his then partner) and dangerous driving. Mr Brown told the police doctor he had schizophrenia, and had been treated in a psychiatric hospital. He said he had tried to hang himself three days earlier, but had no current thoughts of suicide or self-harm. Mr Brown told the doctor he was taking medication for schizophrenia, depression and anxiety, but refused his medication while in police custody.

28. On 12 January, Mr Brown was remanded to Woodhill. He told prison reception staff that he was 'not in a good place', that his head was 'all over the place', and that he had thoughts of self-harm. Staff started ACCT suicide and self-harm prevention procedures. Mr Brown said that he did not want to share a cell because of his mental health problems and staff agreed that he should have a single cell.

29. That day, Mr Brown saw a prison GP who prescribed quetiapine (an antipsychotic medication), venlafaxine (an antidepressant), and omeprazole (to treat excess stomach acid), which Mr Brown said he was prescribed in the community. The GP also referred him to the prison's mental health in-reach team for assessment. Two days later, the GP ended the quetiapine prescription and began aripiprazole (another antipsychotic medication) after receiving Mr Brown's community mental health and GP records which confirmed his prescribed medications.

30. On 13 January, Supervising Officer (SO) A, along with an officer and nurse, held Mr Brown's first ACCT review. Mr Brown said he had schizophrenia, suffered from low self-worth, and had experienced thoughts of self-harm since being abused as a child. Mr Brown said that being on his own helped him to cope, as did maintaining contact with his family, who he was close to. On 20 January, the ACCT was closed after Mr Brown appeared settled, had spoken to his family, had applied for work and had been prescribed his medication.

31. On 20 January, Nurse A, from the prison's mental health team, assessed Mr Brown, following the GP's referral on 12 January. Mr Brown told the nurse he self-harmed as a coping strategy, but had last attempted suicide three days before coming into prison. He said he was under stress, but had no thoughts of self-harm. He said that he did not think his medication was working. The nurse referred him to Dr A, one of the prison psychiatrists.

32. On 26 January, Dr A reviewed Mr Brown, and noted that his schizophrenia had been managed under the Care Programme Approach (an NHS system of delivering community mental health services to individuals diagnosed with a severe mental illness) but had been discharged to be managed by his GP because he was relatively symptom free and stable.

33. Mr Brown said that he had no current thoughts of suicide or self-harm. Dr A concluded that Mr Brown showed no symptoms of schizophrenia and could be monitored and supported by the primary mental health team.

34. On 3 February, Mr Brown told a healthcare assistant that he would not take his medication anymore, although she warned him of the consequences of this. Two days later, on 5 February, he refused to attend a mental health appointment with Nurse A. Later, Nurse B, a mental health nurse, went to see Mr Brown in his cell, but he aggressively told her to go away. The nurse noted that his cell was dirty and his personal hygiene poor. The healthcare team agreed that Mr Brown should move to the prison's inpatient unit for a period of observation.

35. On 8 February, Officer A noted that Mr Brown was upset and had run out of tobacco. Later in the day Mr Brown made superficial cuts to his arms, and told staff that voices outside his window had told him he had AIDS. Officers began ACCT procedures and checked Mr Brown once an hour. Mr Brown had an HIV test, and tested negative.

36. Later on 8 February, Officer B assessed Mr Brown as part of the ACCT process. Mr Brown said that he had cut his arms to release pressure, and that his main concern was that he had run out of tobacco. The officer noted that Mr Brown wanted staff to believe he was fine when clearly he was not, and that he was still refusing to take his medication. The officer got more tobacco for Mr Brown. The next day, Mr Brown agreed to start taking his medication again.

37. On 20 February, staff concluded that Mr Brown no longer needed to be managed under ACCT procedures, because he was settled and had no further concerns.

38. On 23 February, Dr A saw Mr Brown again and noted that he was less muddled and agitated, and less preoccupied with the past. The doctor assessed Mr Brown as well enough to be discharged from the inpatient unit and return to a standard wing, in a single cell, with follow up by the mental health team.

39. On 1 March, Officer C noted that Mr Brown wanted to return to House unit 3 (HU3). She also noted that Mr Brown was upset because he had loaned some tobacco to another prisoner who had now moved without repaying him. The officer told Mr Brown that he should not lend or borrow of tobacco, and that he probably would not get it back.

40. On 3 March, Mr Brown moved to HU3 Spur A and seemed to settle without problems. However, he did not see anyone from the mental health team until 14 April, when he told Nurse A that he was in debt on the wing. She advised him to speak to the unit supervising officer. The nurse did not pass the information on and Mr Brown did not talk about it with unit staff. The nurse noted that Mr Brown appeared unkempt but was otherwise settled and acted appropriately throughout the review. He said he had no thoughts of suicide or self-harm.

41. On 17 April, Mr Brown was convicted at Northampton Crown Court, and remanded to Woodhill to await sentencing. The following day, he told Nurse C that he was hearing voices again and, although they were not upsetting him, he wanted to see someone. The nurse referred him to the mental health team.

42. On 20 April, a pharmacy technician, dispensed Mr Brown's medication and noticed that he had made superficial cuts to his wrists. Mr Brown said that he was feeling very low, heard voices telling him to kill himself, and just wanted to sleep. He said that his medication was not working anymore and said that he felt the same as he had four years ago, when he was detained under the Mental Health Act. The pharmacy technician began ACCT procedures, and staff checked Mr Brown once an hour.

43. On 21 April, SO B assessed Mr Brown as part of the ACCT procedures and noted that he said he was hearing voices telling him to kill himself. Mr Brown said he had self-harmed as a coping mechanism, but did not want to die. The SO told the investigator that he could not remember Mr Brown mentioning that he was in debt or being bullied during the assessment, or at subsequent ACCT reviews. Later that day, SO C chaired Mr Brown's first ACCT case review with Nurse B (this was the first time anyone from the mental health team had seen Mr Brown after Nurse B's referral on 17 April.).

44. Mr Brown said he heard voices and wanted his medication reviewed. The review assessed Mr Brown's risk of suicide and self-harm as low (on a scale of low, raised and high) and reduced his observations to five times during the night with two quality interactions in the morning, afternoon and evening. Nurse C noted in Mr Brown's medical record that he would be discussed at the mental health team meeting and that he remained under the care of the mental health team. SO C noted in the ACCT caremap that Mr Brown would be referred to the psychiatrist.

45. On 23 April, Nurse A carried out a mental health review. Mr Brown said that he was feeling unstable and had asked officers to remove his television because he was hearing voices from it, telling him to kill himself. Mr Brown said that officers had also removed from his cell other objects he could use to self-harm. He said that he had found going to court stressful, and that the police had told his family he was a dangerous man and that they should not have contact with him. The nurse noted that Mr Brown appeared to be overwhelmed. Mr Brown said he had no thoughts of suicide or self-harm, but told the nurse he did not care if he lived or died. The nurse told Mr Brown she would discuss him at the mental health team meeting the next day.

46. On 24 April, SO D, held an ACCT review. No other staff were present but the SO discussed Mr Brown with Nurse B beforehand. The nurse said that healthcare staff were worried about Mr Brown's mental health. At the review, the SO noted that Mr Brown heard voices through his television and acted bizarrely at times. He assessed Mr Brown as a low risk of suicide and self-harm and did not change the frequency of checks. The mental health team (including Dr A) met that day and the doctor increased the aripiprazole dose.

47. On 27 April, Nurse D, a mental health nurse, saw Mr Brown on Nurse A's behalf. Nurse D told Mr Brown that the increased aripiprazole dose would take time to take effect. Mr Brown said that his symptoms were as bad as they had ever been. Mr Brown told the nurse he had asked for a radio to replace the television he had given up; according to the records, he was given a television the next day.

48. On 1 May, SO D, Nurse A and Mr Brown met for an ACCT review. Mr Brown said he felt better now his medication had been increased. He said he had asked

officers to remove his television, as he feared he would still hear voices from it. The SO noted that mental health staff would see Mr Brown every two days to monitor him (there is no evidence in the medical record or ACCT that this happened). The SO noted that staff should encourage Mr Brown to come out of his cell and talk to them. On 3 May, Mr Brown again asked for a television and was given one the next day.

49. Officers told the investigator that Woodhill did not have enough televisions for every prisoner who was entitled to one. They explained that prisoners often traded their televisions with those who were not allowed one (such as those on the lowest level of privileges), in exchange for tobacco or drugs. According to his records, Mr Brown was issued with a number of televisions. Sometimes he asked officers to remove the television because he heard voices from it, but sometimes officers suspected that he had traded it with other prisoners in return for tobacco, or to repay a debt. On some occasions it, seems that other prisoners stole Mr Brown's television from his cell. It is difficult to establish when he had a television in his cell and when he did not.

50. At an ACCT review on 8 May, Mr Brown raised no issues or concerns and said he felt better. The review decided to continue ACCT monitoring for at least another week, given his mood changes and fluctuating mental health. On 12 May, Mr Brown started to attend an anxiety management course, run by Nurse A.

51. On 14 May, Mr Brown spoke to his mother and other family members on the phone. (Prisoners calls are recorded for security reasons and staff listen to a random sample. It does not appear that anyone listened to this call.) His mother told him that she had sent him more money. His sister told him that he should not borrow from other prisoners if he could not pay the debt back. Mr Brown said he was trying to sort himself out.

52. At an ACCT review on 15 May, SO E and Nurse A noted that Mr Brown seemed to be improving and making progress. Mr Brown said he liked attending the anxiety management course and had had no thoughts of self-harm. The SO and the nurse agreed that, if Mr Brown continued to improve, the ACCT could be closed after the next review.

53. On 16 May, Mr Brown told Nurse C that he had made superficial cuts to his arm, following some upsetting family news, but had no current thoughts of self-harm. Staff checked him once an hour and the nurse told the mental health team about his actions. SO F chaired at ACCT review the following day and Nurse C and another officer attended. Mr Brown said he was in a low mood, and would tell staff if he had any thoughts of self-harm. The nurse later noted that he appeared tense but engaged well. Staff continued to check him once an hour and the review made no further entries on the ACCT caremap.

54. On 19 May**,** Mr Brown went to his second anxiety management session. On 21 May, SO E chaired Mr Brown's eighth case review attended by Nurse E and SO F. Mr Brown said he had no current thoughts of self-harm. The staff assessed Mr Brown's risk as low and changed the frequency of checks to one recorded conversation in the morning, afternoon and evening and five checks during the night.

55. On 24 May, Mr Brown's mother told him she had sent him more money and asked if he was still being picked on. Mr Brown told her that he had been picked on because he was in debt, but that he would be okay the following week. He said that the money she had sent in would be a great help, that he had tobacco and was sorting things out. The next afternoon, Mr Brown asked for a television. Officer D said he would try and find him one.

56. On 26 May, in phone call to a friend, Mr Brown said he could not afford to have a television because he was in debt (although officers gave him one on 28 May). Later on 26 May, Mr Brown refused to attend an appointment with Nurse A.

57. On 29 May, SO H chaired an ACCT case review with Nurse E. Mr Brown said he felt better, but still felt at risk of self-harm. He remained under the care of the mental health team and the SO did not alter his level of risk or observations.

58. On 30 May, Mr Brown asked his mother to send in more money because he was in debt. In the afternoon, he told Officer E that other prisoners had stolen the television from his cell, and he said he would hang himself. Officers found him another television, but he refused to take it. A custodial manager, chaired an ACCT review later that day, attended by Officer F, and assessed Mr Brown's risk as raised and increased the frequency of observations to once an hour.

59. On 31 May, Mr Brown phoned his mother and sister, who said the family would try to send in money to help him out. Mr Brown said he would soon be out of debt.

60. On 1 June, SO D chaired an ACCT case review attended by Nurse A. Mr Brown said he was settled now he had his television back, had no thoughts of self-harm and was attending the anxiety management group. No mention was made of other prisoners having stolen Mr Brown's television, or whether staff were investigating this further. The review assessed Mr Brown as low risk and reduced his observations to three conversations a day and five observations during the night.

61. On 2 June, Mr Brown attended another anxiety management session. Nurse B noted that he was again in debt for tobacco and that prisoners were taking things from his cell. There is no evidence that the nurse submitted an intelligence report or passed the information to unit staff, or that anyone took any action to investigate this further.

62. At a case review on 5 June, chaired by SO D and attended by Nurse A, Mr Brown said he was being bullied for his canteen on HU3A as he owed other prisoners tobacco. The SO wrote that Mr Brown had given him the names of the prisoners concerned, however, the SO told the investigator that he did not know the names. The SO noted that he would try and move Mr Brown to Spur B later in the day and noted this in the caremap. Mr Brown said he would be relieved to move off of the spur, but said he had no thoughts of self-harm. The SO noted that Mr Brown appeared settled under the circumstances and assessed him to be a low risk. The SO reduced the observations to two conversations a day and five observations at night.

63. Mr Brown moved from Spur A to Spur B later that afternoon. He said he was happy about moving, and would keep his head down. SO G told the investigator that staff knew about Mr Brown's debt issues on Spur A. She said that Spur A and

B prisoners did not mix apart from when they were moving around the prison, which reduced the possibility of the bullying, however, she often found Mr Brown talking to prisoners at the Spur A gates. The SO said that she told Mr Brown to stay away, for his own sake, but he did not.

64. On 6 June**,** SO G arranged more tobacco for Mr Brown. She told him that she would not be able to do this again and that he would have to work with staff to report bullying and protect his belongings. She told Mr Brown that he could keep his tobacco in the unit office and told him not to get in to debt on Spur B. The SO noted that Mr Brown had understood what she had said to him.

65. At 4.00pm, when collecting his meal, Mr Brown accused another prisoner of looking at him strangely and knocked a plate of food out his hand. Officers intervened and Mr Brown assaulted them. He was restrained and taken back to his cell. SO D noted that it was clear Mr Brown had taken a drug of some kind for him to behave in this manner. No one had any further concerns about Mr Brown that night. Officers told the investigator that Mr Brown's actions were totally out of character and they did not think that he was involved in regular illicit drug use.

66. The following morning, Mr Brown apologised profusely for his actions and said he had no memory of the events. Officers demoted Mr Brown to basic regime with reduced privileges (including no in cell television, reduced access to his prison bank account and reduced time out of cell) and warned him about his behaviour. SO G told the investigator that staff considered whether demoting Mr Brown would increase his risk of suicide and self-harm but concluded that it was a serious assault and demotion to basic regime was an appropriate punishment. Mr Brown remained remorseful of his actions over the following days, but seemed settled.

67. In a phone call to his mother on 9 June, he thanked her for money she had sent in, asked if she could send in more, and talked about his family visiting.

68. On 12 June, SO D and Mr Brown met for an ACCT review. Nurse A provided a report over the telephone. Mr Brown was still upset about having assaulted the two officers. He said he had no thoughts of self-harm, and the SO assessed him as a low risk and did not change the frequency of checks. The SO updated the caremap to reflect that Mr Brown was on basic regime and might need additional support.

69. On 19 June, SO G and Mr Brown met for an ACCT review. No other staff were present, although Nurse A had provided a verbal report to the SO before the meeting. (Nurse A had last seen Mr Brown on 5 June, at an ACCT case review.) Mr Brown told the SO he was happy on Spur B. He said he had some friends on the spur and had been occupying his time working for the waste management unit. Mr Brown said he had no thoughts of self-harm. The SO noted that Mr Brown was still on basic regime, which meant he may have had less access to tobacco. She noted that he had not had any recent contact with the mental health team and that the nurse had agreed that the ACCT could be closed if Mr Brown had not self-harmed recently. The SO closed the ACCT.

70. On 20 June, Mr Brown returned to the standard regime. He spoke to his sister who told him that the family had sent him more money.

71. On 23 June, Officer G submitted an intelligence report because Mr Brown had asked for £50 to be sent to two people in the community who had links with other prisoners at Woodhill. As there was no known link between Mr Brown and the two people he had named, staff investigated further. Officer H spoke to Mr Brown about the requests. Mr Brown said that one of the money transfers was for his sister-in-law and the other for his cousin. Staff were not convinced and did not make the payments. (On 8 July, a third payment of £50 was made to a person Mr Brown described as family. No other money transfers were made to named individuals.)

72. On 25 June, Mr Brown told his mother he might get eight to ten years in prison. Mr Brown said he was in a bit of debt again and his mother said she would send him more money.

73. On 1 July, Mr Brown appeared at Northampton Crown Court. (This was his last appearance in court.)

74. On 6 July**,** the pharmacy technician noted that Mr Brown had complained about a trapped nerve in his arm and had asked for some pain relief medication. This is the last time that Mr Brown was seen by a member of healthcare.

75. On 7 July, Mr Brown refused to attend an appointment with Nurse A. An officer told her that Mr Brown was settled and that staff had no concerns about his behaviour, but that he had asked to have a television in his cell again. Nurse A planned for Mr Brown to be followed up in a mental health review. She was absent from the prison on sick leave shortly after this and did not return to work until after Mr Brown's death. She told the investigator that she had handed over her cases to the other two mental health nurses before she left, but Nurse B said that this had not happened.

76. On 9 July, Mr Brown told SO D that he was okay and that, over the last few weeks, he had not been put under pressure for any of his possessions. This time, the SO wrote that Mr Brown would not give the names of prisoners that had troubled him on HU3A.

77. Mr Brown's last purchase from the prison shop included 87.5g of tobacco. Mr Brown was a heavy smoker, but he also had accumulated debts from borrowing tobacco. We do not know whether Mr Brown was purchasing a large amount of tobacco for his personal use, or to pay off his debts.

Events of 19 July

78. At 11.30am on 19 July, Officer I unlocked Mr Brown to collect his lunch and asked him how he was. Mr Brown told the officer he was okay and the officer had no concerns about him.

79. According to CCTV footage, at 11.35am, while Mr Brown was out of his cell collecting his lunch, two prisoners, A and B, approached his cell. Prisoner A went in while Prisoner B stayed on the landing keeping a look out. A short time later prisoner A left Mr Brown's cell carrying a television, which he took into Mr Brown's neighbour's cell. Officers told the investigator that prisoner A was on basic regime at the time and did not have a television, and that he had taken televisions from other prisoners before.

80. At 11.40am, Mr Brown returned to his cell with his lunch. When Officer J locked his cell door a minute later, Mr Brown told him that his television was missing from his cell. The officer told Mr Brown that he would sort it out after lunch and Mr Brown seemed satisfied with this.

81. At 12.08pm, Mr Brown pressed his cell bell. Officer K, who was the lunchtime patrol for both Spur A and B, answered the cell bell at 12.10pm. The officer said Mr Brown asked to speak to the supervising officer. The officer told Mr Brown that SO G was on her lunch break, but said he would ask her to come to speak to him when she returned. The officer said Mr Brown seemed content with this, raised no concerns, and did not say why he wanted to speak to the SO.

82. After lunch, Officer K told SO G that Mr Brown had asked to speak to her. The SO gave the afternoon briefing to the houseblock officers before prisoners were unlocked. She mentioned that Mr Brown had asked to speak to her and officers told her that his television had been taken from his cell. Officer L said that SO G asked staff to search the cells of prisoner A and other prisoners on basic regime that afternoon. SO G told the investigator she planned to talk to Mr Brown that afternoon and to find him another television.

83. At 1.10pm, Officer I went to Mr Brown's cell. Although Mr Brown was not due to be unlocked, the officer thought he would check Mr Brown first. The officer looked through the cell door observation panel and saw Mr Brown sitting in a chair, facing the window, with his belt tied around his neck. The officer radioed an emergency code blue (which indicates that a prisoner is unconscious or not breathing) and went into the cell. The officer cut the ligature from around Mr Brown's neck and laid him on the floor. The officer said that Mr Brown was still warm, but he could not find a pulse so he began cardiopulmonary resuscitation.

84. A number of other officers responded to the code blue call. Officer M and Officer K collected a defibrillator and other emergency equipment, including oxygen. SO G radioed the control room who said that they had already called an ambulance. The control room log notes that an ambulance was called at 1.10pm.

85. At 1.13pm, Nurse F arrived at the cell. She and officers continued with cardiopulmonary resuscitation. Staff attached the defibrillator, which advised no shock. The ambulance arrived at Woodhill at 1.20pm, and the paramedics reached Mr Brown's cell at 1.23pm and took over resuscitation efforts. Sadly, Mr Brown could not be resuscitated and Dr B pronounced his death at 2.00pm.

86. Mr Brown left a note on his bed addressed to his mother and sister. He wrote that he had not seen or heard from anyone in weeks and asked them to write so he knew that all was well. Mr Brown ended the note by apologising, saying he could not take any more.

Information received after Mr Brown's death

87. On 20 July, an officer submitted an intelligence report noting that two named prisoners had threatened Mr Brown to pay back his debts. One of the prisoners mentioned was placed on anti-bullying procedures, the other had since been released from prison.

88. On 23 July, prisoners told HU3 officers that Mr Brown had been in a lot of debt for tobacco, and that unnamed prisoners were taking advantage of him and increasing the pressure by adding debts that he did not owe.

Contact with Mr Brown's family

89. Two members of staff were appointed family liaison officers. At 4.45pm, they left Woodhill to break the news of Mr Brown's death to his mother at her home in Northampton. Unfortunately, a neighbour had heard the news from another prisoner at Woodhill and had already told Mr Brown's family. The prison offered to contribute to the cost of Mr Brown's funeral in line with national policy.

Support for prisoners and staff

90. Managers debriefed the staff involved in the emergency response. Staff involved said they found it helpful and that the prison's care and welfare team had given them good support. The prison posted notices informing other prisoners of Mr Brown's death and offered support. Officers reviewed prisoners assessed as at risk of suicide and self-harm, in case they had been affected by the news of Mr Brown's death, including those that had been close to him on the spur.

Findings

Managing Mr Brown's risk of suicide

91. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody lists a number of risk factors and potential triggers for self-harm and suicide. These include previous self-harm, court appearances, fear of violence or intimidation, a history of mental health problems and a diagnosis of mental illness.

92. When Mr Brown arrived at Woodhill in January 2015, he said that he was having thoughts of self-harm and had attempted suicide three days earlier. He had been diagnosed with schizophrenia nine years earlier, although he was relatively symptom free and stable on his medication. He had been convicted of his offences but had not yet been sentenced. Mr Brown had also accumulated debts at Woodhill having borrowed tobacco, and there is evidence that he was the victim of bullying and intimidation as a result (which we explore in more detail below).

93. While at Woodhill, Mr Brown was monitored under ACCT suicide and self-harm prevention procedures three times because he had harmed himself or expressed thoughts of suicide and self-harm. The last period of ACCT monitoring ended on 19 June, when SO G considered that he was not currently at risk. On 23 June, an officer submitted an intelligence report suggesting that Mr Brown was still in debt and probably being bullied, although he denied any problems. He did not harm himself, complain of any mental health problems, or express any thoughts of suicide in the weeks before his death.

94. On 19 July, Mr Brown told an officer that other prisoners had stolen his television. On 30 May, when he had last complained of prisoners taking his television, he had said he would hang himself. On this occasion, he did not make any threats and appeared content to wait to speak to the supervising officer after lunch. We are satisfied that officers could not reasonably have foreseen his actions that lunchtime and that it was reasonable not to begin ACCT monitoring.

95. Although Mr Brown had not been monitored under ACCT procedures for some weeks, we have identified some shortcomings in the ACCT process. We are concerned that, on 19 June, SO G closed the ACCT alone. The SO said she felt confident closing the ACCT because she had spoken to Nurse A before doing so, and had consulted other members of staff. She said it was sometimes difficult to hold multidisciplinary reviews because of staff shortages. Neither the nurse nor any of her mental health colleagues had seen Mr Brown in person since 5 June, at an ACCT case review. Furthermore, on 19 June, Mr Brown was still on basic regime with reduced access to tobacco, which was a well established problem for him. We conclude that it would have been sensible to wait until a mental health nurse could attend the review, and for Mr Brown to have returned to standard regime, before ending ACCT procedures.

96. We are also concerned that Mr Brown's last ACCT contained little mention of, and no actions to tackle his debt and the resulting bullying he suffered. Although Mr Brown said that family contact was important to him and made regular calls to his mother and sister, no one considered involving his family in the ACCT process. PSI 64/2011 instructs that staff must consider involving the prisoner's family or next

of kin, if that would be beneficial. It is disappointing that we have raised concerns about the operation of ACCT procedures at Woodhill in several recent investigations. We make the following recommendation:

The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidance, including:

- **Multi-disciplinary approach for all case reviews, in particular for review members to be present when considering closure of ACCT procedures.**
- **Setting and updating specific and meaningful ACCT caremap objectives to address the underlying causes of a prisoners distress.**
- **Involving the prisoner's family/next of kin when that would be beneficial.**

Victim Support

97. It is not clear when Mr Brown first incurred debts from borrowing tobacco at Woodhill, but certainly he had done so by May. Officers on HU3 knew about his debt and vulnerabilities and had warned him about the risks of borrowing and lending possessions.

98. At an ACCT review on 5 June, Mr Brown told SO D he was being bullied and had had items taken from his cell. The SO wrote in the ACCT document that Mr Brown had given him the names of the bullies. However, the SO later told the investigator that Mr Brown had not named anyone. Officers also suspected that Mr Brown often traded his television with other prisoners, perhaps to pay off debts or to borrow more tobacco. Although staff arranged for Mr Brown to move spurs later there is little evidence that anyone formally investigated his concerns, tried to identify the perpetrators or took any action to tackle the behaviour. (It was only after Mr Brown's death that a prisoner was put on anti-bullying monitoring.)

99. Woodhill has a local violence reduction and anti-bullying strategy. The policy highlights the process for investigating all incidents of bullying behaviour and providing on-going monitoring of the perpetrator. However, the policy offers little guidance on what support should be given to the victim, although a support plan for victims is incorporated into the perpetrators monitoring booklet. Mr Brown was never monitored using formal victim support measures, which we consider he should have been.

100. In June 2011, a Prisons and Probation Ombudsman's "learning lessons" report found that evidence of bullying and intimidation featured in 20 per cent of the self-inflicted deaths we considered. In a follow up report issued in October 2011, on violence reduction, bullying and safety, we identified the importance of implementing local violence reduction strategies, investigating all allegations of bullying and recognising that prisoners who have been victims of bullying may be at greater risk of suicide and self-harm. We make the following recommendation:

The Governor should ensure that all information indicating bullying and intimidation is fully investigated and that apparent victims are effectively supported and protected with meaningful solutions which address their individual situation, including through ACCT procedures where appropriate.

Mental Health

101. The clinical reviewer, noted that, initially, Mr Brown was regularly seen by members of the mental health team. He was prescribed appropriate medication and saw the prison psychiatrist. However, from 5 June until his death on 19 July, Mr Brown had no face to face contact with anyone from the mental health team. Mr Brown refused to attend an appointment with Nurse A on 7 July, and after that date, the nurse, his allocated nurse, was on sick leave.

102. Nurse A said she would have handed over her caseload to her colleagues while she was on sick leave, but Nurse B told the investigator and clinical reviewer that there was no formal protocol for transferring cases when a colleague was absent. In any case, Mr Brown had no contact with the mental health team for a period of six weeks before his death, despite his mental health diagnosis and ongoing difficulties.

103. The mental health nurses said they carried large caseloads, which were sometimes unmanageable, due to staff shortages. Nurse A said she had raised the issue with her managers, but the numbers had remained high. Her experience reflects the findings of the most recent unpublished inspection by HM Inspector of Prisons.

104. The clinical reviewer noted that the difference between ACCT reviews and formal mental health reviews was unclear. He noted that, once Mr Brown had been discharged from the psychiatrist's care, the only mental health reviews to take place appear to have happened as part of the ACCT case reviews, which is not appropriate.

105. The clinical reviewer concluded that the standard of mental health care given to Mr Brown was not equivalent to what he could have expected in the community. We make the following recommendation:

    The Head of Healthcare should ensure that there is a fully staffed mental health team and that mental health reviews are completed appropriately and to the required standard.

Prisons & Probation Ombudsman
Independent Investigations

PO Box 70769
London, SE1P 4XY

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

T | 020 7633 4100
F | 020 7633 4141