Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of James Brown a prisoner at HMP Humber on 14 June 2016

A report by the Prisons and Probation Ombudsman
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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 James Brown was found hanged in his cell at HMP Humber on 14 June 2016. He was 29 years old. I offer my condolences to Mr Brown's family and friends.

Mr Brown was serving an indeterminate sentence for public protection. He was nine years past his minimum tariff of one year, seven months and 3 days. He was despairing of his prospects of release and his deteriorating behaviour and mental health reflected this despair. His death is a sad reminder of the stress and uncertainty that prisoners serving indeterminate sentences can face.

Mr Brown's mental health declined rapidly before he died. A psychiatrist assessed that he required a transfer to a secure mental health unit, but the transfer process was mismanaged and resulted in Mr Brown remaining in prison for far longer than he should have, with tragic consequences.

Mr Brown's behaviour was often challenging and he frequently self-harmed. It is disappointing that Humber did not consider implementing the enhanced case management process, which would have enabled proper oversight of his issues, a more informed approach to managing and mitigating his risk of suicide and self-harm and, possibly, a less tragic outcome.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **September 2017**

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Summary

Events

1. Mr James Brown was sentenced to an indeterminate sentence for public protection (IPP) in October 2005. Despite being eligible for release from May 2007, he never managed to convince the Parole Board that he was ready for release. Mr Brown arrived at Humber in June 2014.

2. Mr Brown had a history of drug misuse in the community and continued to misuse drugs, including new psychoactive substances (NPS), while in prison. He was diagnosed with personality disorders, had a low IQ and his behaviour was often challenging. Mr Brown had no history of suicidal thoughts or self harm before June 2014; subsequently he frequently self-harmed and was managed under Prison Service suicide and self-harm procedures (ACCT) on 17 occasions.

3. Mr Brown's mental health deteriorated rapidly shortly before he died, apparently as he became more hopeless about his prospects of ever being released. In April 2016, a prison psychiatrist assessed Mr Brown as needing specialist treatment in a secure mental health unit. Attempts were made to find a suitable place for treatment, but a bed had not been secured by the time of Mr Brown's death.

4. On 14 June, Mr Brown was being observed three times an hour as part of his ACCT management. At 9.58pm, a night patrol officer asked Mr Brown to remove paper which he had used to cover his observation panel. Mr Brown swore at him and he informed the night manager. The night patrol officer checked him again at 10.08pm and 10.15pm and recorded that he could see Mr Brown sitting in the corner of his cell, but did not get a response from him. When the night manager had finished dealing with another incident in the prison, he sent staff to Mr Brown's wing. At 10.35pm, staff entered Mr Brown's cell and found him with a strip of sheet tied around his neck, attached to a shelf in the corner of his cell. Staff and paramedics were unable to resuscitate him and, at 11.10pm, recorded Mr Brown had died.

Findings

5. Mr Brown was a young man who voiced despair at being in prison many years after his minimum tariff. He displayed complex behaviours, resulting in frequent indiscipline and self-harming. Staff did not use enhanced case management procedures, which would have provided better oversight of his issues and more consistent multi-disciplinary input into his risks and how to address them. The ACCT procedures that were employed were inadequate. Case reviews were poorly attended, with some being missed altogether (including one on the day he died), and caremaps were not properly completed or reviewed.

6. On the day Mr Brown died, although the night patrol officer informed the night manager that Mr Brown had covered his observation panel, he failed to tell him when he could no longer obtain a response from Mr Brown. This resulted in a delay in sending officers to open the cell and the discovery that Mr Brown had used a ligature to hang himself. There was a delay of 27 minutes between the

night patrol officer no longer getting a response from Mr Brown and the calling of the medical emergency code.

7. In April 2016, a prison psychiatrist assessed Mr Brown as requiring treatment at a secure mental health unit. Humber NHS, who provided psychiatric care, did not follow national NHS guidance for transferring prisoners to a secure hospital under the Mental Health Act, which resulted in a significant and unjustifiable delay. Transfers should take place within 14 days but Mr Brown had been waiting for over seven weeks when he died.

8. Mr Brown was candid with staff about his use of NPS at Humber, yet there is little evidence that Mr Brown was advised of the risks of NPS or that he was supported to stop using these drugs.

9. Mr Brown's family were upset that Humber notified them of his death by telephone the morning after his death. Staff failed to provide adequate support to prisoners and staff who had been affected by Mr Brown's death.

10. There were significant logistical challenges in the early part of the investigation where the investigator found effective engagement of the prison difficult and which required the direct intervention of the Governor before they were resolved.

Recommendations

- The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, in particular:
    - Enhanced case management procedures should be used to manage prisoners with complex behaviours;
    - Case reviews should be multi-disciplinary and involve the prisoner's family where it would be beneficial;
    - Caremaps should contain actions that are specific, time bound and meaningful, tailored to the individual to reduce their risks and updated at each case review.
- NHS England Yorkshire and The Humber should ensure that the specialist commissioning of mental health and psychiatric services follow national guidance for s47/s48 assessments and transfer to mental health units. The healthcare provider should also ensure:
    - NHS England and the Ministry of Justice Mental Health Casework Section are promptly notified when a prisoner is assessed as requiring such a transfer;
    - Healthcare staff work in partnership with community services to ensure continuity of care;
    - Healthcare staff work in partnership with the prison to ensure an integrated care plan / behaviour modification plan is in place for prisoners with learning difficulties/disabilities.

- The Governor should review decision-making procedures around the use of special accommodation and the location of prisoners at risk of suicide and self harm in the segregation unit and ensure the segregation unit operates in line with the national policies set out in PSO 1700.
- The Governor should remind staff that when an observation panel is covered and a prisoner fails to respond, arrangements should be made to enter the cell as quickly as possible, particularly in the case of prisoners being monitored under ACCT arrangements.
- The Head of Healthcare should ensure substance misuse services are effective and provide:
    - Swift access to appropriate support;
    - Improved communication with the mental health team, substance misuse service and prison staff about individuals' presentation and needs;
    - Details of all interventions from substance misuse services are fully recorded in prisoners' records.
- The Governor should ensure that a family liaison officer informs a prisoner's family quickly and in person of their death, in line with national guidance.
- The Governor should ensure that prisoners who request additional support following a death in custody are responded to within 24 hours.
- The Governor should ensure that, in line with PSI 58/2010, the Prison and Probation Ombudsman is promptly provided with all requested documents following a death in custody

The Investigation Process

11. The investigator issued notices to staff and prisoners at Humber, informing them of the investigation and asking anyone with relevant information to contact her. One prisoner responded.

12. On 15 June, when the PPO were notified of Mr Brown's death, the relevant extracts from Mr Brown's prison and medical records and closed circuit television (CCTV) coverage of the events of 14 June were requested. Although the records were ultimately provided, liaison arrangements at Humber were not in line with expectations and there were significant delays in receiving the correct documents and arranging formal interviews. The Governor at the time was made aware of the difficulties.

13. The investigator was unable to visit Humber until 11 July, when she spoke to several prisoners who knew Mr Brown and staff and prisoners on D Wing.

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

15. The investigator interviewed 11members of staff and five prisoners at Humber, in August and September; interviews with healthcare staff were conducted with the clinical reviewer. The investigator also interviewed two members of staff from City Health Care Partnerships, by telephone, in June 2017.

16. We informed HM Coroner for East Riding and Kingston upon Hull of the investigation who gave us the results of the post-mortem examination. We suspended our investigation in September 2016 pending the outcome of the police investigation, but re-started in May 2017, when we received confirmation from Humberside Police that criminal charges would not proceed. We have sent the coroner a copy of this report.

17. One of the Ombudsman's family liaison officers telephoned Mr Brown's family on 20 June to explain the purpose of the investigation. During a meeting on 12 July, Mr Brown's family had a number of questions and concerns about his care in prison. They wanted to know how Mr Brown was able to take his own life when being regularly watched, why the family were not involved in the ACCT process, why they were told Mr Brown had died over the telephone and why he was on closed visits.

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

19. The prison also received a copy of the report and identified no factual inaccuracies.

Background Information

HMP Humber

20. HMP Humber is a medium security prison in Yorkshire that holds approximately 1,000 men. It was formed in 2014 by the merger of two previously separate prisons, HMP Wolds and HMP Everthorpe. City Health Care Partnership (CHCP) provides healthcare services. There are healthcare staff on duty at all times and the mental health team work on weekdays. At the time of Mr Brown's death, Humber NHS were contracted to deliver psychiatric services, but their contract ended on 31 May 2016. Since 1 June 2016, CHCP have commissioned psychiatric services, via locum doctors.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Humber was in July 2015. Inspectors reported that the use of new psychoactive substances (NPS), and the resulting debt, was a significant issue and that drug availability was high. Inspectors found that triggers for suicide or self-harm were not always well identified in the ACCT process and the quality of comments varied. Procedures to keep prisoners safe were underdeveloped, although the quality of ACCT documents and procedures had improved. Inspectors reiterated that all prisoners should have 24 hour access to Listeners. The senior management team introduced ACCT refresher training, weekly safer custody meetings and daily reports. Inspectors reported that the mental health team regularly attended ACCT case reviews, but only 11% of prison staff had received mental health awareness training.

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 first annual report for the combined Humber prison, for the year to December 2015, the IMB reported that there had been initiatives introduced at Humber to counter the use of NPS, including speaking individually to each prisoner and running NPS workshops. The Board was concerned about the effective use of ACCTs in managing those with mental health issues, although noted safer custody had improved after a poor audit at the start of the year.

Previous deaths at HMP Humber

23. Mr Brown was the fifth prisoner to die at HMP Humber since November 2015, and the second to take his own life. There have been two self-inflicted deaths since Mr Brown died. In previous investigations, we have found that prison staff did not fully consider the risk of suicide and self-harm and took too long to enter a cell in an emergency.

Assessment, Care in Custody and Teamwork

24. 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.

25. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. 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 on the caremap 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.

New Psychoactive Substances (NPS)

26. New psychoactive substances, previously known as 'legal highs' are an increasing problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of NPS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health.

Transfer of Prisoners to Hospital under the Mental Health Act

27. PSI 50/2007 (Transfer of Prisoners To and From Hospital Under Sections 47 and 48 of the Mental Health Act 1983) and NHS England's 'Good Practice Guide – The transfer and remission of adult prisoners under s47 and s48 of the Mental Health Act' outline the process for transferring a prisoner to hospital under the Mental Health Act. The NHS guidance recommends that all such transfers take place within 14 days of the Secretary of State issuing a warrant for transfer. In October 2007 a revised version of 'Procedure For The Transfer Of Prisoners To And From Hospital Under Sections 47 And 48 Of The 'Mental Health Act (1983)' was issued. This document acknowledges there had been unacceptable delays in transferring prisoners, and provides a best practice flowchart for all key stakeholders.

28. Two independent reports by a medical practitioner, one of whom has to be approved under Section 12(2) of the Mental Health Act (1983), need to assess the same form of mental disorder and the need for inpatient treatment before the Secretary of State will issue a warrant for transfer. These assessments are valid for two months. The PSI and best-practice flow-chart clearly state that the MoJ Mental Health Casework Section must be informed when a prisoner is first assessed as needing to transfer to a mental health unit.

Segregation Units

29. Segregation units are used to keep prisoners apart from other prisoners. This can be because they feel vulnerable or under threat from other prisoners or if they behave in a way that prison staff think would put people in danger or cause problems for the rest of the prison. Segregation is authorised by an operational manager at the prison who has to be satisfied that the prisoner is fit for segregation after an assessment by a member of healthcare staff.

Parole Board

30. The Parole Board for England and Wales is an independent public body. Its role is to make risk assessments about prisoners to decide whether they can safely be released into the community once they have served the minimum term imposed by the courts.

Indeterminate Public Protection Sentences (IPP)

31. Indeterminate public protection sentences were abolished in 2012. They were intended to protect the public against offenders whose crimes were not serious enough to merit a normal life sentence, but who could only be released once they had served their minimum tariff and had demonstrated to the satisfaction of the Parole Board that they had sufficiently reduced their risk.

Key Events

32. Mr James Brown was remanded to HMP Hull on 7 May 2005, charged with robbery, burglary and motoring offences. He was 18 years old and had been to prison before. On 7 October, Mr Brown was sentenced to an indeterminate sentence for public protection (IPP) with a minimum term to serve of one year, seven months and three days. This meant he was eligible for release from 10 May 2007, subject to the Parole Board being satisfied that he was no longer a risk to the public.

33. When Mr Brown arrived in prison he had no physical health problems. There were no specific concerns about his mental health although he had a long history of drug misuse, reportedly from the age of 11-12 years old, and healthcare staff were concerned he may have an anti-social personality disorder and possible learning disabilities. An undated report by a senior nurse of the Learning Disability Service at HMP Hull concluded that Mr Brown did not have a specific learning disability but he had a low IQ of 66, resulting in him struggling to process information and needing support to fully understand what was being asked of him.

34. Mr Brown spent time at Moorland, Everthorpe, Doncaster and Hatfield prisons over the next eleven years. During this time his behaviour was challenging, and he was frequently placed on report (known as adjudication). In total, Mr Brown had over 40 adjudications.

35. In 2012, Mr Brown had seizures, probably as a result of his drug use. Although he had a CT scan, he refused to attend follow up appointments with a neurologist for further tests to establish the exact cause of his seizures. He was prescribed anti-epilepsy medication.

36. Mr Brown had three parole reviews before the Parole Board directed he could be transferred to open conditions at Hatfield on 4 September 2013. Mr Brown was returned to closed conditions at Doncaster on 24 October when he was suspected of being involved in a burglary.

June 2014 – 27 May 2016

37. On 5 June 2014, at Doncaster, Mr Brown (and two other prisoners) damaged prison property, stole canteen and were placed on report. The next day Mr Brown cut his right arm and told a nurse he did not intend to kill himself, but just felt ‘down’. This was the first recorded incident of self-harm.

38. Mr Brown was moved to Humber on 9 June 2014. In total, between 6 June 2014 and 14 June 2016, staff started ACCT procedures on 17 separate occasions. Mr Brown frequently self-harmed by cutting himself and, on one occasion, cut off, and tried to eat, the top of his ear. On two occasions, he told staff he had taken an overdose of paracetamol. Mr Brown often told prison and healthcare staff that his IPP status frustrated him and he felt hopeless about his prospect of release. He asked for help with his drug misuse and received treatment from the integrated drug treatment service (IDTS) and drug alcohol recovery service (DARS). He was also under the care of the mental health in-reach team, but did not always attend his appointments. Although healthcare staff thought he should

share a cell for his own safety, due to his seizures, Mr Brown threatened to harm himself and signed a disclaimer that he wanted to be in a single cell.

39. Mr Brown often displayed aggressive, challenging behaviour at Humber. Although he had periods of being more settled and compliant, his behaviour was often poor, and included stealing from, and bullying, other prisoners. Staff had concerns that Mr Brown continued to misuse drugs.

40. Mr Brown told his offender supervisor that he was worried he would never get out of prison and needed help with his drug misuse. She referred him for a psychology assessment as part of the parole process. After Mr Brown had cut off, and tried to eat, the top of his ear on 29 July, she contacted the mental health team to ask if Mr Brown should be sectioned under the Mental Health Act, but was reassured Mr Brown's needs were being met by the mental health in-reach team and IDTS and DARS. Mr Brown was placed on and successfully completed a methadone detoxification programme at the end of September 2014, but prison staff continued to have concerns that he misused drugs and was mixing with other prisoners who were a bad influence.

41. On 2 November, the Parole Board concluded that Mr Brown should remain in closed conditions. They cited a decline in his prison behaviour and concerns he would quickly relapse into drug misuse and offending were he to be released. Staff told Mr Brown the outcome of the decision on 10 November. The next scheduled parole review was May 2017.

42. On 4 January 2016, a prison GP examined Mr Brown at his request and started him on a small dose of methadone (10ml). He advised Mr Brown he needed to engage with the substance misuse services for support.

43. On 12 January 2016, the visiting psychiatrist assessed Mr Brown and concluded that he had emotionally unstable and anti-social personality disorders. He discussed coping strategies, including psychological treatment. Mr Brown told him he did not think his anti-depressant (mirtazapine) helped him. The psychiatrist gave him information on another drug to consider (depakote) to help stabilise his mood, which also prevents seizures. Mr Brown told him that he wanted to wait until his release to address his personality disorders.

44. On 14 January, Mr Brown told a nurse from the mental health team that he wanted to try depakote, which was prescribed the next day. (This medication was stopped in April, as Mr Brown said it increased his thoughts of suicide.) Mr Brown asked to see someone from IDTS about his methadone reduction programme. A prison GP reviewed Mr Brown later the same day and agreed to increase his methadone to 20ml, although noted Mr Brown wanted to remain on a maintenance programme, rather than strive to reduce and stop methadone.

45. Over the next three months, Mr Brown was frequently thought to be under the influence of NPS, was managed under ACCT procedures after he cut his neck and arms, and made threats to kill himself. Mr Brown did not attend appointments with the mental health team, including those with the psychiatrist. On 17 February, Mr Brown wrote to the psychiatrist and explained his feelings of hopelessness and that he found it difficult to express himself. Mr Brown also wrote that he heard voices and had suicidal thoughts.

46. Due to his deteriorating mental health, the care programme approach (CPA - an NHS system of delivering community mental health services to individuals diagnosed with a severe mental illness or other vulnerabilities such as a history of violence or self-harm) started on 18 March. On 24 March, a mental health nurse saw Mr Brown, who admitted using drugs, said that he could not cope with being in prison and did not think he could stay drug free while in custody. She discussed alternative coping strategies and she referred Mr Brown for an appointment with the psychiatrist. Later the same day, Mr Brown threatened a prison GP and two IDTS dispensing staff. Mr Brown was unhappy that his methadone dose was to be reduced by 2mls a month. On 29 March, Mr Brown told an officer he did not feel ready to reduce or come off methadone and worried he would feel ill and would start misusing subutex again (an opiate substitute).

47. On 19 April, Mr Brown stole another prisoner's medication from the dispensing hatch; he returned the medication a short while later. The next day at around 10.00am, healthcare staff were called to the wing as Mr Brown had cut his stomach and arm. Mr Brown said he was frustrated and had smashed his television and kettle because he had been removed from his cleaning job, as a result of his poor behaviour. An hour later, healthcare staff returned to Mr Brown's cell as he had cut himself again and was heavily under the influence of NPS; he was not given his dose of methadone. Humber have a zero tolerance policy to drug use and, in line with their local policy for those found using illicit drugs, Mr Brown was placed on closed visits for three months. He was reduced to basic on the IEP scheme. There is no evidence prison staff reviewed Mr Brown's IEP status before he died.

48. On 15 May 2016, while living on K Wing, Mr Brown was throwing items around his cell. Prison staff went to speak to him and Mr Brown placed a ligature around his neck, attached to the light fitting, and knelt down in an attempt to hang himself. Prison staff quickly entered his cell, cut the ligature and began ACCT procedures. Mr Brown said he was frustrated at being locked up.

49. On 18 May, an offender supervisor recorded in Mr Brown's prison record that it was the first time in a long while Mr Brown did not appear to be under the influence of drugs. Mr Brown told her that he realised he was going to end up dead if he kept taking drugs and that his mental health problems were all related to his drug use. Mr Brown spoke about his family and said he wanted to stay away from drugs as he hoped to be released in 2017. The ACCT was closed the next day.

50. On 26 May, a prison GP reviewed Mr Brown with IDTS. Mr Brown stated that he was no longer using drugs and wished to stop taking methadone. Mr Brown's methadone dosage started to be reduced gradually but was then stopped abruptly as he refused his methadone on 1 and 3 June, and his prescription was cancelled.

Events from 27 May 2016

51. A custodial manager began ACCT procedures at 1.19am, after Mr Brown set fire to his cell on K Wing in an attempt to kill himself. Mr Brown told her that he wanted to smash his head against the wall until he died as it was his time to go. Staff believed Mr Brown was under the influence of NPS. She completed the

immediate action plan which recorded that Mr Brown was to be moved to the segregation unit, as there were no other safer cells available. Observations were set at five times each hour until he could be assessed by the mental health team. She recorded that she explained how Mr Brown could access the telephone, that he was given anti-rip clothing (special clothing made of material extremely difficult to tear into strips to create ligatures), but was not able to speak to a Listener as he was located in the segregation unit.

52. At 2.40am, Mr Brown took off his anti-rip clothing and attempted to strangle himself. An operational support grade (OSG) requested assistance from night managers, who quickly responded. He was given new anti-rip clothing but did not put them on. Mr Brown stood in his cell urinating, which he rubbed on his face. At 3.16am, the OSG offered Mr Brown a cigarette. Mr Brown said the tobacco had told him to eat it and tried to choke himself with the pouch of tobacco. Night managers were still on the wing, they calmed Mr Brown down, his cell was cleaned and by 4.15am he was asleep.

53. An officer carried out an ACCT assessment at 8.45am. Mr Brown said he heard voices due to coming off NPS and had set fire to his cell because the voices told him to and he wanted to die. Mr Brown told her that he felt better, but was paranoid that staff were spying on him and had put a camera in his television to watch him. Mr Brown told her he did not have any plans to die, but was still hearing voices. He said his parents were supportive and that he was happy on K Wing as he had friends there and wanted to go back there. She noted that Mr Brown would be referred to the custodial manager from the mental health team and a move back to the wing would be considered.

54. The custodial manager and a worker from DARS visited Mr Brown at 9.45am. He was distressed and tearful and felt staff had targeted him. Mr Brown wanted his own clothes returned. Throughout the morning, Mr Brown shouted at other prisoners, and told prison staff that he could hear people talking about him.

55. The custodial manager for Safer Custody was assigned as Mr Brown's ACCT case manager, and chaired an ACCT review later the same day at 2.15pm, with a Supervising Officer (SO) and Mr Brown. There was no mental health or healthcare representative and nobody from the substance misuse services at the review. The officer who completed the initial assessment spoke to the case manager, but was not able to attend the review. The case manager recorded that Mr Brown had been moved to D Wing, a standard residential wing, around 10.40am. They reviewed the use of anti-rip clothing and Mr Brown had already had his own clothes returned. Mr Brown's level of assessed risk of suicide or self-harm was recorded as raised and observations reduced to hourly. The case manager noted one issue on Mr Brown's caremap that he should be supported with withdrawing from NPS. Healthcare staff, D Wing staff and DARS were tasked with this action. The next case review was scheduled for 3 June. Staff continued to manage Mr Brown under ACCT procedures until his death. The case manager did not attend any of the subsequent ACCT case reviews.

56. On 3 June, a SO chaired an ACCT review with an officer, an offender supervisor (but not Mr Brown's offender supervisor) and Mr Brown; again there was no mental health or healthcare representative and nobody from the substance

misuse services. The SO recorded that Mr Brown said he had no intention of suicide or self-harm, that he had been using NPS for a long time but was now not using and that he wanted to earn release as he had a chance of parole in 2017. The caremap was not reviewed or updated. The review considered Mr Brown's risk of suicide or self-harm had reduced to low, and the ACCT was closed. A post-closure review was scheduled for 10 June.

57. On 7 June at around 9.20am, Mr Brown refused to return to his cell and told prison staff he wanted to move to the segregation unit. An officer persuaded Mr Brown to go back to his cell, but a few hours later Mr Brown smashed items in his cell and told staff he had cut his arm. The ACCT was re-opened, but there was no new assessment.

58. A SO conducted an ACCT review with only himself and Mr Brown in attendance, at 1.30pm. Mr Brown refused to engage, but said he wanted to move to the segregation unit. He recorded Mr Brown was very irate and threatened him with violence. He considered Mr Brown was at a high risk of suicide or self-harm and that he should be observed five times each hour. He did not update the caremap. The next review was scheduled for 8 June, but this did not take place and no reason was entered on the ACCT as to why the review did not happen.

59. On 9 June, the acting custodial manager for Safer Custody chaired a case review with Mr Brown. An officer from D Wing is recorded to have provided a verbal contribution, but did not attend the review. Mr Brown's risk of suicide and self-harm was reduced to low, as he appeared to be more settled and Ms Kenington recorded 'he is feeling good today'. Mr Brown said he was aware his mental health issues affected his behaviour, and the mental health team were to be invited to the next review. The custodial manager recorded there were no outstanding issues and that the caremap had been reviewed, although there is no evidence that it was. Observations were reduced to hourly, with a conversation to take place during association, and the next review scheduled for 13 June.

60. A visiting psychiatrist sent an e-mail at 12.50pm on 10 June, to the Humber Centre, requesting admission of Mr Brown to their medium secure learning disability unit. He noted Mr Brown was 'currently presenting with symptoms of psychosis, potentially driven by polysubstance misuse… There are significant risks associated with his mental disorder… There are significant concerns over his safety and risk to others'. A bed was identified at Newton Lodge, but was not allocated before Mr Brown died.

61. On 13 June, a SO chaired the ACCT review at 3.50pm which Mr Brown attended. It records that two officers 'attended on further review' but it is not clear how they contributed or if they did attend a formal review. The SO recorded that Mr Brown refused to engage.

62. A prison chaplain visited Mr Brown on D Wing. He noted in the ACCT, and told the SO, that Mr Brown had told him that he was suicidal, had visions of hanging and was 'expressing a clear determined intention'.

63. The SO contacted a prison manager for advice on whether Mr Brown should be placed in anti-rip clothing and located in a safer cell. Mr Brown later told the SO

that he had lied to the chaplain and had no intention of killing himself. She recorded at 5.45pm, that 'the [ACCT] board were happy that Mr Brown does not intend to self-harm following his admission'. She recorded Mr Brown's assessed risk of suicide or self-harm had increased to raised. Observations were increased to three an hour. The ACCT was scheduled to be reviewed the next day, but the review did not take place and there is no record why it did not happen. The front cover of the ACCT appears to have been overwritten; the date of the review has been altered from 13 June to 14 June, with the next scheduled review 15 June.

64. Closed circuit television (CCTV) was given to the investigator to verify the timings of staff interactions on D Wing, but there was no time stamp on the recording and images were unclear. Humberside Police were also unable to establish exact timings of events, but viewed the footage at the prison and provided an outline of events. CCTV shows the chaplain helping to lock up prisoners and around 6pm, speaking briefly to Mr Brown. He made an entry in Mr Brown's ACCT at 6.10pm, and noted that 'he seemed OK'. He told Mr Brown to press his cell bell if he 'felt down'. There is no comment or decision recorded regarding the SO's earlier request for a safer cell and anti-rip clothing to be considered.

Tuesday 14 June 2016

65. Mr Brown had a settled night. At 8.50am, he asked to speak to the custodial manager. Mr Brown was told she was not on duty, but that he had an appointment booked with her on Thursday 16 June. At 2.05pm, Mr Brown pressed his cell bell. He asked if all the recording in his cell could be stopped. An officer changed the subject to distract Mr Brown. At 3.20pm, Mr Brown asked to come out of his cell as there was 'pressure in his cell'. He helped clean the landing, to distract him, and he was recorded to be in 'good spirits'. Mr Brown collected his evening meal and medication and went out to exercise. CCTV showed Mr Brown pacing around the wing until prisoners were locked up. This behaviour was not considered unusual for Mr Brown. Throughout the early evening Mr Brown lay on his bed and watched his television.

66. An OSG started work at around 8pm and signed the ACCT document to acknowledge he had to complete three observations an hour. He recorded in Mr Brown's ACCT that he was watching television at 8.22pm and 8.40pm and asleep at 9.24pm and 9.39pm. When he got to Mr Brown's cell at 9.58pm the observation panel was covered with toilet paper. He asked Mr Brown to remove the paper, but he refused and swore at him; he also said he had barricaded his door. He informed the night manager that he required assistance.

67. The night manager and his colleagues said there were two other prisoners that evening, in separate parts of the prison, who were also on an ACCT and threatening to harm themselves. He said he had to transfer one prisoner from L Wing to G Wing, which were about 10 minutes apart, and needed the other officers on duty to ensure this was done safely as the prisoner had a weapon and had threatened to cut himself.

68. In the meantime, the OSG returned to Mr Brown's cell and at 10.08pm recorded in the ACCT, 'I can now see Brown sat in the right hand corner of his cell as part of the toilet roll has moved and can now see the right hand side of his cell'. The

last entry on the ACCT by him was at 10.15pm. He recorded 'Brown is sat in the right hand corner of his cell looking at his cell floor'. When interviewed, he told the investigator that when he returned to Mr Brown's cell at 10.08pm, he could not get a response from him, but he thought he saw his arm moving, although he had failed to record this in the ACCT document.

69. On completion of the other prisoner's move, the night manager stayed on G Wing but sent the four officers to Mr Brown's wing (D Wing), a short distance away. Officer A told the investigator that they all went into the wing office to put on latex gloves for their own protection, as Mr Brown was known to self-harm. He said from arriving at D Wing and getting to Mr Brown's cell was less than two minutes. Humberside Police told the investigator that CCTV showed two officers arrived on D Wing between 10.20pm and 10.30pm and Officer A and another officer arrived around 10.30pm.

70. When they arrived at Mr Brown's cell, Officer B looked through the gap in the observation panel, and saw Mr Brown sitting on the floor, hanging by a sheet attached to a corner shelf. He unlocked the cell and forced open the door to dislodge a locker and television that Mr Brown had placed by the door. He and Officer C cut the ligature and lowered Mr Brown to the floor. He radioed a cold blue medical emergency at 10.35pm and an ambulance was requested. The three officers started cardiopulmonary resuscitation (CPR). A nurse responded quickly to the emergency request. There were no signs of life and a portable defibrillator indicated there was no shockable rhythm, but CPR continued until paramedics arrived.

71. Yorkshire Ambulance Service confirmed they received a request for an emergency ambulance at 10.36pm. A first responder arrived at Humber at 10.49pm, and a minute later an ambulance. At 11.10pm, paramedics recorded that Mr Brown had died.

Contact with Mr Brown's family

72. Two family liaison officers recorded they left the prison at 2.10am to break the news of Mr Brown's death to his family and offer condolences. However, they recorded there was no answer at Mr Brown's home address and returned to the prison at 3.47am. The news of Mr Brown's death was broken to them over the telephone the next morning at 7.40am. Humber contributed towards the costs of Mr Brown's funeral, in line with national instructions.

Support for prisoners and staff

73. After Mr Brown's death, the duty governor debriefed the staff involved in the emergency response. He offered his support and that of the staff care team. Humberside Police informed the investigator that Officer C was not given sufficient support by Humber and was expected to return to his duties, despite being traumatised by Mr Brown's death. He has subsequently resigned from the Prison Service.

74. The prison posted notices informing other prisoners of Mr Brown's death, and offering support. Staff reviewed all prisoners considered to be at risk of suicide and self-harm, in case they had been adversely affected by Mr Brown's death. A

friend of Mr Brown told the investigator he was deeply traumatised by Mr Brown's death and did not feel adequately supported, which was echoed by other prisoners on D Wing.

Post-mortem report

75. A pathologist concluded that Mr Brown had died from hanging. A toxicology report confirmed a therapeutic level of mirtazapine was detected in Mr Brown's blood, but no other substances, at the time of his death.

Findings

Management of Mr Brown's risk of suicide and self-harm

76. Prison Service Instruction (PSI) 64/2011 - *Safer Custody*, requires all staff who have contact with prisoners to be aware of the triggers and risk factors that might increase the risk of suicide and self-harm, and take appropriate action. The risk factors were also listed in our thematic report *"Risk Factors in Self-Inflicted Deaths in Prisons"* published in 2014. Those that applied to Mr Brown included impulsiveness; previous self-harm; history of mental health problems; lack of social support; recent contact with psychiatric services; a history of substance misuse; irrational behaviours; and transfer to another establishment (or secure hospital).

77. The ACCT procedures used to manage Mr Brown's risk of suicide and self-harm were inadequate. They failed to properly identify and address his risks. Neither the mental health team nor the substance misuse team were involved in his ACCT reviews or his offender supervisor, who had asked to be invited to reviews. Mr Brown's very significant mental health and substance misuse issues were key to understanding and addressing his risk, and specialists from these disciplines, with knowledge of Mr Brown's complex issues, should have contributed to his case reviews. It would also have helped to ensure that staff communicated with Mr Brown in an appropriate way, given his low IQ and communication difficulties.

78. We also found that the ACCT procedures were not carried out in line with guidance. Assessments were not always carried out after an ACCT had been opened, case reviews were missed, caremaps were not reviewed or updated, and essential caremap actions (particularly in respect of arranging Mr Brown's transfer to a secure hospital) were not identified. No consideration was given to involving Mr Brown's parents in the ACCT reviews, despite PSI 64/2011 stipulating procedures must be in place to encourage family engagement in managing and reducing the risk of prisoners who harm themselves and/or others, where this would be beneficial. An officer said senior managers had instructed staff that they could not offer prisoner's telephone calls or contact their families, but since Mr Brown's death they are now encouraged to do so.

79. PSI 64/2011 advises that prisoners with disruptive and challenging behaviours should be subject to enhanced case management procedures in order to effectively manage their heightened risk of harm to themselves and/or others. Enhanced case management is overseen by a senior case manager and ensures there is consistent multi-disciplinary input into managing the prisoner's risk. We consider that staff should have considered enhanced case management for Mr Brown. He had been diagnosed with personality disorders, was a frequent self-harmer, often displayed challenging behaviour and was repeatedly subject to disciplinary action.

80. Staff accounts and records of some of the events of 13 and 14 June are contradictory and unsatisfactory. A SO contacted a chaplain on 13 June to ask whether anti-rip clothing and a safer cell should be considered. This was recorded on the ACCT. The chaplain spoke briefly to Mr Brown, but did not record what his decision was regarding the safer cell and anti-rip clothing issues.

During his police interview, the chaplain denied he had been contacted by the SO, although two other officers present in the wing office corroborated the SO's account of events.

81. At the case review on 13 June, a review had been scheduled for the next day, the day Mr Brown died. It did not happen. On 14 June, the wing manager and the acting custodial manager were both aware that Mr Brown's ACCT was due for review as it was discussed at the daily briefing. Each blamed the other during prison investigation interviews for it being missed. The front of Mr Brown's ACCT was altered from 13 June, to 14 June, with the next review scheduled for 15 June. An officer told Humberside Police that he altered the ACCT on the instruction of the SO. His reasons for doing so were considered by the police to be implausible, and not supported by CCTV footage of staff interactions or statements made to the police by other officers.

82. The officer was suspended from duty between 30 September and 16 January, pending the outcome of the police investigation. The police also investigated the actions of other staff, and the actions of the SO were also considered. The CPS decided not to proceed with criminal charges. The Prison Service is conducting an investigation into their actions and those of a manager, under the terms of PSI 06/2010 and AI 05/2010 - *Conduct and Discipline*, which we would otherwise have recommended.

83. Mr Brown's risk of suicide and self-harm was extremely poorly managed on many levels. We make the following recommendation:

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

- **Enhanced case management procedures should be used to manage prisoners with complex behaviours;**
- **Case reviews should be multi-disciplinary and involve the prisoner's family where it would be beneficial;**
- **Caremaps should contain actions that are specific, time bound and meaningful, tailored to the individual to reduce their risks and updated at each case review.**

Delay in transfer to secure mental health unit

84. In January 2016, we published a thematic review of lessons to be learned from our investigations into self-inflicted deaths in prisons where mental health issues were involved. We noted that where a secure hospital had been identified as the best environment to deliver appropriate care for acutely ill prisoners, we would expect all possible steps to be taken by the prison and the hospital to ensure this takes place within the 14 day target. We also noted that prisons need to be extra vigilant about the care of prisoners who are being considered for, or are awaiting transfer to a secure hospital.

85. Healthcare staff at Humber first identified that Mr Brown needed treatment in a secure hospital on 26 April. The next day a psychiatrist referred Mr Brown to the Humber Centre for a 'gatekeeping assessment'. A prison GP who ultimately

recommended transfer to a medium secure unit (in a learning disability setting), completed this assessment nearly a month later on 23 May, but her report was not completed until 10 June. She concluded her report 'Bearing in mind the current difficulties with his [Mr Brown's] management, I would ask an appropriate facility for him should be identified as swiftly as possible'. The Section 12 assessments required before a transfer warrant can be issued were never completed. The delay was particularly tragic as a place for Mr Brown had been identified at Newton Lodge, and a transfer could have taken place within days.

86. There is no evidence Mr Brown was kept informed and no evidence his family were consulted or invited to support Mr Brown, as outlined in the Good Practice guidance. A custodial manager told the investigator Mr Brown had the capacity to make his own decision, and did not want his parents to be involved.

87. The psychiatrist, who worked for Humber NHS, told the investigator it was common practice at that time not to request the Section 12 assessments and a transfer until a bed had been secured. The mental health manager at Humber, who had raised his concern about non-compliance with national guidance, said prisons across Yorkshire and Humber followed Humber NHS Specialised Mental Health Services Pathway Protocol. A member of City Health Care Partnership said Humber NHS followed a different protocol, which conflicted with national guidance. Humber NHS had been commissioned to provide psychiatric services in line with national guidance and, as they were unable to do so, had their contract terminated on 31 May 2016.

88. The clinical reviewer concluded that the care Mr Brown received at Humber was not equivalent to that which he could have expected in the community. She found the Care Programme Approach was inadequately implemented and the procedures for transferring Mr Brown to hospital under S47 of the Mental Health Act 1983 were not followed. Contact with the Ministry of Justice and NHS England Health & Justice Commissioning Team should have been made much earlier. Mr Brown had been waiting for admission to a secure hospital for seven weeks, when this should have taken place within 14 days. Had the proper process been followed, Mr Brown's death might have been prevented. We make the following recommendation:

NHS England Yorkshire and The Humber should ensure that the specialist commissioning of mental health and psychiatric services, follow national guidance for s47/s48 assessments and transfer to mental health units. The healthcare provider should also ensure:

- **NHS England and the Ministry of Justice Mental Health Casework Section are promptly notified when a prisoner is assessed as requiring such a transfer**;
- **Healthcare staff work in partnership with community services to ensure continuity of care;**
- **Healthcare staff work in partnership with the prison to ensure an integrated care plan / behaviour modification plan is in place for prisoners with learning difficulties/disabilities.**

Segregation and special accommodation on 27 May

89. Prison Service Order (PSO) 1700 - *Segregation* states, 'Segregation should be used only as a last resort whilst maintaining a balance to ensure it remains an option for disruptive prisoners. This does include prisoners on an open ACCT plan, but only when they are such a risk to others that no other suitable location is appropriate and where all other options have been tried or are considered inappropriate'. Special accommodation should only be used for the shortest necessary time, to prevent a violent or refractory prisoner injuring others, damaging property or creating a disturbance. PSI 64/2011 states that prisoners on open ACCT plans must only be located or retained in segregation units in exceptional circumstances and that the reasons for segregation must be clearly documented and include other options that were considered but discounted.

90. Mr Brown was segregated at 1.19am on 27 May, after he set fire to his cell and ACCT procedures were started. Humber did not provide any documentation relating to Mr Brown's segregation or the decision to place him in special accommodation and anti-rip clothing. A manager said there were no spare cells in the establishment as a number of cells were out of commission and the segregation unit was the only safe place to locate Mr Brown. She said she obtained a verbal agreement from the on call manager, but the oncall manager did not recall this.

91. PSO 1700 requires that a member of healthcare completes an initial segregation health screen, within two hours, and the duty manager completes the authority to segregate, detailing the exceptional circumstances for locating a prisoner on an open ACCT in segregation, as well as the measures in place to safeguard their mental health. A nurse had examined Mr Brown and recorded in the medical record the initial healthscreen algorithm was completed, however we saw no evidence of any of this. She noted Mr Brown was located under restraint, made continued threats to harm himself and was distressed. She noted she had some concerns about Mr Brown being in segregation, but considered it was the safest location for him at that time.

92. We are concerned that Humber could not produce the documentation justifying the decision to place Mr Brown in the segregation unit while on an ACCT, and the use of special accommodation. In addition, we did not have sight of the healthscreen algorithm. We make the following recommendation:

    The Governor should review decision-making procedures around the use of special accommodation and the location of prisoners at risk of suicide and self harm in the segregation unit and ensure the segregation unit operates in line with the national policies set out in PSO 1700.

Delay in discovering Mr Brown

93. At 9.58pm on 14 June, the night patrol officer asked Mr Brown to remove the paper he had used to cover his observation panel. When Mr Brown refused to do so, he informed the night manager. This is in line with the guidance contained in PSI 24/2011 - *Management and Security of Nights*, which states that the night manager should be informed if an observation panel is covered, and they should

arrange for officers to attend to enter the cell. The OSG was told by the night manager that he could not send officers straightaway because he was dealing with the movement of another prisoner on an ACCT and required the officers on duty to attend to that incident first.

94. The night manager returned to Mr Brown's cell at 10.08pm and recorded that he could see through a gap in the paper that Mr Brown was sitting in the corner of his cell. The OSG told the investigator that he could not get a response from Mr Brown but thought he saw his arm moving, but he did not record this in the ACCT document. Given that Mr Brown was assessed as being at heightened risk of suicide and self-harm and had covered his observation panel, we consider that once he failed to get any response from him, he should have communicated this urgently to the night manager. When interviewed, the night manager said that had he been informed that Mr Brown was failing to respond, he would have arranged for an officer to attend straightaway. The OSG described Mr Brown as 'very childish… very awkward' and that he often behaved in a way to hinder staff. He made the assumption when he got no response that Mr Brown was simply being difficult.

95. All four response officers were on D Wing by 10.30pm. They went to the office first and put on gloves, before going to Mr Brown's cell. The medical emergency code was not called until 10.35pm - 27 minutes after the OSG had failed to obtain a response from Mr Brown.

96. While we cannot say whether earlier intervention would have prevented Mr Brown's death, it is critical that staff act quickly in situations such as this. We make the following recommendation:

The Governor should remind staff that when an observation panel is covered and a prisoner fails to respond, arrangements should be made to enter the cell as quickly as possible, particularly in the case of prisoners being monitored under ACCT arrangements.

Management of Mr Brown's substance misuse

97. Mr Brown had a history of substance misuse, which continued while in prison. He engaged intermittently with the integrated substance misuse services, and received support with his opiate addiction including being prescribed methadone. He completed a detoxification programme in September 2014, but was unable to remain drug free and was a frequent user of NPS. In July 2015, we issued a Learning Lessons Bulletin about the use of NPS, including the dangers to both physical and mental health and the possible links to suicide and self-harm. The bulletin identified the need for better awareness among staff and prisoners of the dangers of NPS.

98. Although the post-mortem toxicology results indicate Mr Brown had not used illicit drugs immediately before his death, he used NPS frequently and heavily while at Humber. It is evident that the use of NPS at Humber is a continuing problem. We note that HM Inspectorate of Prisons was very concerned about the prevalence of NPS when they inspected the prison in December 2015. In its

most recent annual report, Humber's Independent Monitoring Board also identified NPS as a serious concern.

99. Humber issued a staff information notice on 13 April, about managing the risks associated with NPS. Prisoner mentors had been appointed to work with the drug strategy team and be involved in the induction process for new prisoners, to help promote awareness of the dangers of NPS and reduce the demand for such substances. The prison had published a protocol about how staff should respond when they suspected a prisoner of using NPS. As the prison has taken steps to address the supply and demand for NPS we do not make a further recommendation, but stress the need for continuing effort to reduce supply and demand for illicit substances and for all staff to be aware of the risks of the use of NPS, particularly when prisoners are assessed as at risk of suicide and self-harm.

100. At the time of Mr Brown's death, Humber's drug rehabilitation programme delivered by Lifeline, did not allow prisoners to remain on a maintenance programme, and all prisoners were expected to comply with a reduction programme. A prison GP told the investigator that he believed some prisoners benefitted from being on a maintenance programme, such as Mr Brown. A manager confirmed CHCP now commission substance misuse services, which allows for a more flexible approach to individual programmes.

101. **The Head of Healthcare should ensure substance misuse services are effective and provide:**

- **Swift access to appropriate support;**
- **Improved communication with the mental health team, substance misuse service and prison staff about individuals' presentation and needs;**
- **Details of all interventions from substance misuse services are fully recorded in prisoners' records.**

Family liaison

102. Prison Rule 22 requires prisons to inform the next of kin immediately if a prisoner dies. PSI 64/2011 gives a mandatory instruction that, wherever possible, this must be done in person by a family liaison officer and another member of staff. Despite a family liaison officer recording there was no answer at Mr Brown's home address, Mr Brown's family was adamant that nobody from the prison had visited and they were very upset at how the news was broken to them.

103. The family liaison officer told the investigator that the decision to notify Mr Brown's family by telephone was made, in agreement with the duty governor, to avoid them being notified by prisoners using illicit mobile phones. He said when he returned to the prison around 7.15am, prisoners were already discussing Mr Brown's death and he did not want his parents to find out this way. We consider that Humber should have arranged for them to be told in person. The family liaison officer made the telephone call at 7.40am, 25 minutes after he returned to duty. The distance from the prison to the address is approximately 18 miles / 30 minutes and it is not unreasonable that somebody from the prison should have been immediately directed to break the news in person.

The Governor should ensure that a family liaison officer informs a prisoner's family quickly and in person of their death, in line with national guidance.

Support for staff and prisoners

104. Humberside Police informed the investigator that Officer C had resigned from the Prison Service, allegedly due to the trauma of discovering Mr Brown, the lack of subsequent support and had been expected to continue his duties without Humber ensuring he was emotionally fit to do so. We do not have any further evidence of these alleged failings so do not make a formal recommendation. Nevertheless, Humber should ensure the provision of support for staff as outlined in PSI 08/2010 - *Post Incident Care* after a death in custody.

105. A prisoner told the investigator that he had little support in the weeks after Mr Brown's death, and described his frustration and despair in trying to talk to someone. He said he broke prison rules by climbing onto the netting on the landing in an attempt to get someone in authority to listen to him.

106. PSI 64/2011 states that prisons must ensure that they have procedures in place to support prisoners who have been affected by a death in custody. We found that Humber had not responded to the prisoner's, and other prisoners', requests for support following Mr Brown's death and had they have done so, his act of indiscipline could have been avoided. We therefore make the following recommendation:

The Governor should ensure that prisoners who request additional support following a death in custody are responded to within 24 hours.

PPO liaison arrangements

107. Following the notification of Mr Brown's death, a large box of uncollated papers dated between 2005 – 2016, some of which related to a different prisoner, was received by the PPO in June 2016. It took until the end of August, some two months after Mr Brown's death, for us to receive all relevant documents. Arranging interviews was time consuming and problematic. Despite raising the issues directly with the prison's nominated liaison, things did not improve until the investigator contacted the Governor directly. Although communication improved subsequently, we make the following recommendation:

The Governor should ensure that, in line with PSI 58/2010, the Prison and Probation Ombudsman is promptly provided with all requested documents following a death in custody

Prisons & Probation Ombudsman
Independent Investigations

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By email: [redacted]

Dear Sir

INVESTIGATION INTO THE DEATH OF MR JAMES BROWN, WHILE A PRISONER AT HMP HUMBER, ON 14 JUNE 2016

We represented Humber Teaching NHS Foundation Trust at the Inquest touching upon the death of James Brown. It took place over 3 weeks in December 2018. You will recollect our client corresponded with you in early 2018 concerning the above referenced report prepared following your investigation into the death of Mr James Brown who was a Prisoner at HMP Humber on 14 June 2016.

Unfortunately, the report contains material inaccuracies in relation to the involvement of Humber Teaching NHS Foundation Trust and there are errors of fact within the report, which then impact upon some of the conclusions reached. The report was not shared with the Trust in time so it could make representations when it was in draft form and you have previously declined to consider revising the report. However, it is factually inaccurate.

The Inquest touching upon the death of Mr Brown concluded on 21 December 2018.

The PPO Report

The report states at paragraph 3:-

> *"Mr Brown's mental health deteriorated rapidly shortly before he died, apparently as he became more hopeless about his prospects of ever being released. In April 2016, a Prison Psychiatrist assessed Mr Brown as needing specialist treatment in a secure mental health unit. Attempts were made to find a suitable place for treatment, but a bed had not been secured by the time of Mr Brown's death".*

And at paragraph 7 of the report:-

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> *"In April 2016, a Prison Psychiatrist assessed Mr Brown as requiring treatment at a secure mental health unit. Humber NHS who provided psychiatric care did not follow national NHS guidance for transferring Prisoners to a secure hospital under the Mental Health Act, which resulted in a significant and unjustifiable delay. Transfers should take place within 14 days but Mr Brown had been waiting for over 7 weeks when he died".*

Further at paragraph 85 of the report:-

> *"Healthcare staff at Humber first identified that Mr Brown needed treatment in a secure hospital on 26 April. The next day a Psychiatrist referred Mr Brown to the Humber Centre for a gatekeeping assessment. A Prison GP, who ultimately recommended transfer to a medium secure unit (in a learning disability setting), completed this assessment nearly a month later on 23 May, but her report was not completed until 10 June. She concluded in her report "bearing in mind the current difficulties with his management, I would ask an appropriate facility for him should be identified as swiftly as possible". The Section 12 assessments required before a transfer warrant can be issued were never completed. The delay was particularly tragic as a place for Mr Brown had been identified at Newton Lodge, and a transfer could have taken place within days".*

At paragraph 88:-

> *"Mr Brown had been waiting for admission to a secure hospital for 7 weeks, when this should have taken place within 14 days".*

The Issue

As is clear from the extracts above, the report suggests that a decision was made on 26 April 2016 that Mr Brown required treatment in a medium secure hospital setting.

This is not correct. [redacted] the prison Psychiatrist, was not saying as at 26 April 2016 Mr Brown required treatment in a medium secure hospital setting. This was his evidence on oath at the Inquest in December. He referred Mr Brown for an assessment as to his suitability for transfer to hospital out of Prison. Statistics vary but Dr [redacted] confirmed at the Inquest that potentially up to 70% of the Prison population have a personality disorder (as Mr Brown did), and the vast majority of these individuals are treated within the Prison setting.

Dr [redacted] confirmed at the Inquest that he followed the process as set out by NHS England when an adult secure mental health hospital bed may be needed. We attach the relevant NHS England document in use at the time, entitled *"Adult Secure Mental Health and Learning Disability Inpatient Services – Referral and Access Assessment Guidance".*

Dr [redacted] confirmed at the Inquest he was following the process as set out in this document for securing a medium secure hospital bed. This was the process the Commissioners required the Trust to follow.

The document should be studied in full but the process as to timescale is set out at paragraph 8. This was a routine referral and the timescale at paragraph 8.5 was followed in this case in that the multi-disciplinary assessment took place within 1 month of the referral – the referral letter being dated 27 April 2016 and the assessment taking place on 23 May 2016. NHS England's guidance then states that a formal written report is to be shared within 2 weeks – in this case that would be by 6 June 2016: in this case, a referral meeting took place at the Humber Centre on 6 June 2016 and Mr Brown was accepted as being suitable for treatment in hospital at this stage. Whilst a written

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report was not available until 10 June 2016, the Commissioners (NHS England) were advised of Mr Brown's need for a bed immediately and on 7 June 2016 a potential placement had indeed been identified at Newton Lodge. Arrangements were being made for an assessment by Newton Lodge (who had to undertake their own assessment before they could conclude whether they could offer Mr Brown a bed). If they were able to offer the bed to Mr Brown the necessary application to the MoJ would be made for the authority to transfer.

The Trust were following the process laid down by the Commissioners in terms of securing a medium secure hospital bed in Mr Brown's case. The initial assessment process is a key part of the process and this was made clear at the Inquest. For example, it was necessary to determine whether Mr Brown would be best suited to a PD or an LD unit, and had this not been carefully considered, the risks to Mr Brown may have escalated as is evident from Dr [redacted] report. It was reasonable and appropriate that the referral was made for an assessment and this was accomplished within the timescales set down by NHS England. The PPO report suggests that the transfer should have occurred within 14 days of 26 April and this is simply factually wrong. Dr [redacted] is referred to as a Prison GP which is also incorrect, and Dr [redacted] is not a Visiting Psychiatrist.

The Trust are very concerned that the PPO report has been published but is materially inaccurate in that it suggests the prison Psychiatrist was saying as at 26 April 2016 Mr Brown needed to be in a hospital setting and 7 weeks later this had not been accomplished. This incorrect factual assertion leads to unjustified and inappropriate findings concerning delay. The transcripts of the interviews of relevant staff are at times difficult to follow and understand. There was no criticism of the Trust at the Inquest. Your office can obtain the Inquest transcript.

As a matter of natural justice the report must be revised to correct these issues; failing that it is important this letter is published alongside it in a suitably anonymised form as an Appendix setting out this issue for the record. Otherwise the report is potentially defamatory.

If the report is not revised or this letter published as an Appendix to it please provide us with detail of the complaints process as the Trust may wish to pursue this further.

Yours faithfully

[redacted]
HEMPSONS
[redacted]
d: [redacted]
e: [redacted]

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