

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Bradley Brown a prisoner at HMP Buckley Hall on 14 August 2017

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*



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

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Bradley Brown died on 14 August 2017 after hanging himself in his cell at HMP Buckley Hall. Mr Brown was 31 years old. We offer our condolences to his family and friends.

Mr Brown had been in prison since April 2016. This was not his first period of imprisonment. He was described as someone who understood prison rules and procedures and coped well. He had no history of self-harming, either in custody or in the community. Mr Brown demonstrated some challenging, violent, behaviour and spent time in four different prisons. He was transferred to Buckley Hall three days before his death. He raised no concerns on arrival and during the weekend telephoned his mother, sounding upbeat and giving no cause for concern.

On 14 August, at approximately 7.30am, staff found Mr Brown's observation panel blocked when carrying out a routine roll check. When officers opened the door, they discovered him hanging. Staff immediately called an emergency and the ambulance service was contacted. Staff began resuscitation attempts but paramedics pronounced Mr Brown dead at 7.45am.

There was nothing in Mr Brown's actions or documented history that would indicate that he was at risk.

Concerns about a possible delay in finding Mr Brown are being investigated by the prison, but we are not able to say whether earlier intervention might have prevented Mr Brown's death.

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

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Summary

Events

1. On 22 April 2016, Mr Bradley Brown was remanded into custody at HMP Liverpool charged with conspiracy to supply drugs. He was sentenced to four years imprisonment on 7 June 2016. He spent time at four different prisons, with two separate stays at both Liverpool and HMP Haverigg. While at Haverigg for the second time, between 29 March and 11 August 2017, staff recorded Mr Brown's behaviour as problematic. This culminated in Mr Brown getting into fights with other prisoners, and subsequently being transferred to HMP Buckley Hall on 11 August.
2. When he arrived at Buckley Hall, Mr Brown reported no concerns and denied any thoughts of self-harm or suicide. Throughout his time in custody, Mr Brown had never expressed any suicidal thoughts or intent or been subject to suicide or self-harm monitoring procedures. Although he had some pre-custodial mental health history, including a past psychotic episode, for which he had been prescribed medication, he had not had any problems while in prison and was not receiving treatment for mental health issues.
3. Mr Brown telephoned his mother twice on 11 August and again on 13 August. During these calls Mr Brown sounded upbeat, and did not say anything that would cause concern. Over the weekend, he was unlocked for periods of association, exercise, and to collect his meals, and did not raise any concerns. Prison staff said that Mr Brown did not appear to be under stress or worried, and when spoken with, was polite and amicable.
4. On 14 August, at approximately 7.30am, staff found Mr Brown's observation panel blocked. When officers opened the door, they discovered him hanging from the light fitting. Staff immediately cut the ligature from his neck and called a medical emergency code. The control room contacted the ambulance service at 7.34am. Staff started cardiopulmonary resuscitation (CPR), and efforts to resuscitate him continued until paramedics arrived at 7.44am when they completed a heart trace. They pronounced Mr Brown dead at 7.45am.

Findings

Roll checks

5. An OSG carried out a roll check on C wing between 6.00am and 6.15am on 14 August. In a statement provided to the police, she said that when she reached Mr Brown's cell, the observation panel had been blocked by a piece of material hanging on the inside of the door. She did not attempt to gain a response from Mr Brown and said that she heard a noise, which she thought had come from inside the cell. She agreed that she should have taken time to gain a response from Mr Brown. If she could not confirm Mr Brown's well-being visually, she should have reported this to a senior colleague. Her actions are currently the subject of an internal investigation at Buckley Hall.

6. The investigation is not able to say whether earlier intervention would have prevented Mr Brown's death but, in other cases, correctly carrying out such routine safety precautions may prevent an ill or dying prisoner going unnoticed.

Emergency response

7. When prison staff entered Mr Brown's cell and realised what had happened, they immediately called an emergency code blue. According to the control room log, the initial call was received at 7.30am and a request for an ambulance was received by the ambulance service at 7.34am. Prison staff and the healthcare assistant on duty responded quickly. There were no delays in obtaining emergency equipment or with the ambulance service gaining entry to the prison.

Assessment of risk

8. Mr Brown had been in custody on a number of occasions, and had never been subject to self-harm and suicide monitoring. When asked, Mr Brown always denied having any intention to self-harm or thoughts of suicide. He had no history of either in the community.
9. There were no indicators or any documented history available to staff at Buckley Hall on Mr Brown's arrival that suggested that he might be at risk. Staff assessed him appropriately and allocated him a single cell based on his potential risk to others.

Clinical care

10. A clinical reviewer completed a review of Mr Brown's medical care on behalf of NHS England. She has concluded that care received by Mr Brown was of a reasonable standard and was at least equivalent to that which he could have expected to receive in the community.

Recommendations

- The Governor of HMP Buckley Hall should review the procedures for roll checks and ensure that, when being carried out, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that require attention

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Buckley Hall informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
12. The investigator visited Buckley Hall on 21 August. He obtained copies of relevant extracts from Mr Brown's prison and medical records.
13. The investigator liaised with Greater Manchester Police and obtained statements taken from prison staff.
14. NHS England commissioned a clinical reviewer to review Mr Brown's clinical care at the prison.
15. We informed HM Coroner for Manchester North of the investigation. He gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.
16. One of the Ombudsman's family liaison officers contacted Mr Brown's mother, to explain the investigation and to ask whether she had any matters she wanted the investigation to consider. Mr Brown's mother has asked us to establish whether staff followed procedures correctly on the night of 13 August.
17. Mr Brown's family received a copy of the initial report. The solicitor representing the family 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.

Background Information

HMP Buckley Hall

18. HMP Buckley Hall is a medium secure training prison for adult male prisoners serving sentences of four years or more. Manchester Mental Health and Social Care Trust (MMHSCT) provide health services.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Buckley Hall was conducted in June 2016. Inspectors reported that Buckley Hall was a generally safe prison. Prisoners were positive about their reception into the prison, despite some unwelcoming first night accommodation, and levels of violence were low. Inspectors commented that arrangements to support those prisoners considered to be at risk of self-harm were adequate but levels of self-harm had increased since their last inspection in 2012.

Independent Monitoring Board

20. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest published annual report, for the year to July 2017, the IMB reported that Buckley Hall remained, fundamentally, a safe prison for prisoners, staff and visitors. The weekly Safer Regimes meetings were attended during the year by Board Members and they reported that it provided a detailed and informed discussion, in a multidisciplinary forum, of prisoners who were potentially at risk. Staff in the Safer Custody Department were judged by the Board to be well led and committed.

Previous deaths at HMP Buckley Hall

21. Mr Brown's death is only the second apparently self-inflicted death at Buckley Hall since June 2004. There are no similarities between the earlier death and that of Mr Brown.

Key Events

22. Mr Bradley Brown was remanded in custody at HMP Liverpool on 22 April 2016, charged with conspiracy to supply class A drugs. On reception at Liverpool, a nurse completed a health screen. Mr Brown reported no concerns about his physical or mental health. Mr Brown also told her that he had never self-harmed and had no thoughts or intentions of doing so.
23. On 7 June, a Crown Court sentenced Mr Brown to four years imprisonment. Mr Brown's custodial behaviour was often challenging and he could be confrontational, non-compliant and abusive towards staff. This behaviour resulted in several periods spent in segregation, restricted regimes, and ultimately, having days added to his sentence. When he was compliant, Mr Brown actively engaged with work and offending behaviour courses. During this period of custody, Mr Brown was transferred six times and spent time at four different prisons in the North West between 22 April 2016 and 11 August 2017. He was at Liverpool and Haverigg twice each. Some of the transfers were the result of his poor behaviour, others were requested by Mr Brown so that he could engage in offending behaviour courses.

HMP Haverigg

24. Mr Brown was transferred to HMP Haverigg from HMP Hindley at his own request, for the second time on 29 March 2017. He had previously been at Haverigg for three months, in 2016. On arrival at Haverigg, a nurse completed a health screen with Mr Brown during which he raised no concerns about his physical health. A mental health nurse also completed a mental health assessment. Mr Brown told her that he had seen a mental health nurse at Hindley, but this had been so he could 'get off basic', referring to the basic privileges level. He said that once taken off the basic regime, he had stopped seeing mental health services. As with previous health screens, Mr Brown denied having ever self-harmed in the community or custody, and denied having any such thoughts. There was no evidence to suggest otherwise.
25. Mr Brown's reported racist behaviour continued to attract negative comments from staff, and staff raised concerns about his behaviour leading to possible altercations with other prisoners.
26. On 3 June, a Custodial Manager (CM) spoke with Mr Brown after he made threats to stab his cellmate. She recorded that there was a degree of manipulation and there was no risk to his cellmate. Wing staff indicated to her that Mr Brown was due for the next available single cell. She recorded that Mr Brown had no history of violence against other prisoners but that there was a previous 'alert' for violence in relation to gang membership. She recorded that during his earlier spell at Haverigg, Mr Brown had told staff he had assaulted cellmates and therefore required a single cell. She recorded that there was no evidence to support this.
27. On 15 June, Mr Brown was considered by staff to be suitable for the Challenge to Change programme at Haverigg and he appeared to be motivated to engage. He said that he was looking forward to spending some time with his daughter on

the prison's family days. He was also hoping to develop skills to be a more positive father.

28. Mr Brown's partner is in custody at HMP Styal. The couple have a young daughter, for whom Mr Brown's mother is the sole carer. Inter-prison telephone calls between Mr Brown and his partner were arranged at least twice.
29. However, Mr Brown's behaviour deteriorated. He assaulted another prisoner, was believed to have been intoxicated, was found in possession of a mobile phone and was involved in a fight with two other prisoners. He also declined the Challenge to Change course. He was vocal and threatening and demanded a transfer from Haverigg.
30. On 6 August, Mr Brown spoke to a CM, who recorded that Mr Brown was kept in his cell following a fight with two other prisoners. He recorded that Mr Brown stated a few times that "if you don't get me out of here it will go off". He also said that when he was let out of his cell, it would "go off".
31. The CM recorded that Mr Brown's threats of violence had increased over the past week. Mr Brown denied being in debt, but staff believed that his problems with other prisoners were debt-related. He was relocated to the segregation unit on 7 August, where he remained until he transferred to HMP Buckley Hall on 11 August.

HMP Buckley Hall – 11 to 14 August

32. Healthcare staff spoke with Mr Brown briefly on his reception at Buckley Hall and he reported no concerns. An officer completed a first night induction at 4.30pm. He recorded that there were no immediate concerns, although Mr Brown was a high-risk cell share, which meant he required a single-occupancy cell. Staff gave Mr Brown some tobacco and he made a telephone call to his mother at 4.37pm. He told the officer that he was happy to be at Buckley Hall and that he had no thoughts or intent of self-harm.
33. During the telephone call to his mother, which was listened to by the investigator, Mr Brown told her that Buckley Hall was "alright" and that he knew a couple of other people there. Mr Brown did not sound distressed or upset. The call lasted seven minutes.
34. Once he had completed the reception and first night process, Mr Brown was located in a single cell on C wing, the induction wing. He made a further telephone call to his mother at 5.03pm. The conversation with his mother continued from their previous conversation. He asked his mother if she had heard from his partner and asked about his daughter. Nothing in Mr Brown's tone or in what he said would suggest he was upset or distressed.
35. Mr Brown was requested to attend a new reception health screen on Saturday 12 August, but failed to do so. No reason for his non-attendance was recorded.
36. Over the weekend, Mr Brown was unlocked for periods of association, exercise, and to collect his meals. He did not raise any concerns. Officer A, who was on duty on C wing during Sunday 13 August, said that she first met Mr Brown that morning when he asked her if she had a bowl and cutlery. She said she recalled

- Mr Brown attending the servery for lunch and dinner and collecting his milk and cereal for the following morning. She said that Mr Brown did not appear to her to be stressed or worried, and when she had spoken with him, he had been polite and amicable.
37. Mr Brown telephoned his mother at 2.47pm. Mr Brown asked how his daughter was, and told his mother that the food at Buckley Hall was good. During the call, Mr Brown did not sound upset, and he finished the call by telling his mother that he would try to call again later that week.
 38. Staff locked prisoners back in their cells for the night at around 5.00pm. Officer A said she spoke with Mr Brown just before she locked his cell and asked him if he needed anything else. He said he did not, and thanked her for getting him the bowl and cutlery earlier in the day. She said that they both said goodnight and she locked the cell door.
 39. On the evening of 13 August, an Operational Support Grade (OSG) was on night duty on C wing. She explained that during night duty she is responsible for attending to any requests from prisoners, completing hourly patrols of the wing, completing roll checks and checking any prisoners who may be subject to monitoring under suicide and self-harm prevention measures. She said that on 13 August, no prisoners on C wing were subject to any additional monitoring.
 40. During the night, the OSG had no reason to go to the cell occupied by Mr Brown. At approximately 6.00–6.15am, she began a morning roll check. This required her to go to every cell to ensure that the correct number of prisoners were on the wing. She has said in a statement that she was feeling unwell on 13/14 August, and that she completed her roll check quicker than she normally would have done for this reason.
 41. When the OSG reached Mr Brown's cell, she opened the observation panel and noticed that the panel was blocked from the inside. She was unable to see into the cell. In a statement provided to Greater Manchester Police, she said that although she could not see into the cell, she did hear what she described as a 'bang' from inside. She said that on hearing this, she was satisfied that someone was inside. She did not attempt to get a response from Mr Brown and she did not inform anyone else that the observation panel was blocked. CCTV shows her approaching the cell and opening the observation panel; she remains at the door for around three seconds before moving away.
 42. Officer B arrived for duty on C wing at 7.24am and received a handover from the OSG. He asked whether there were any issues that he needed to be aware of and she replied that it had been a "settled" night. He then began his roll check.
 43. Officer B said that he started his check, looking into the cell through the observation panel. He explained that he was checking to ensure that the cell doors were secure, the prisoner was present and that he was alive and well.
 44. Officer B reached Mr Brown's cell at approximately 7.27am. On opening the observation panel, he discovered a blue towel blocking his view into the cell. He said that this is a regular occurrence when prisoners are using the toilet, seeking privacy or doing something that they should not. He knocked on the door and

- asked Mr Brown to remove the towel. He repeated this request but got no response. He then tried to look down the sides of the door. He said that his view was limited, but the toilet area was vacant and he could not see Mr Brown on his bed.
45. Officer B said that could just see Mr Brown and that his toes were touching the floor and his knees were slightly bent. He could see the outline of Mr Brown's torso, arm and head, but could not be sure whether Mr Brown was standing in the cell or if he had ligatured. He requested assistance using his radio. He said that this was within one minute of arriving at the cell.
 46. Officer B continued to call to Mr Brown and ask him to remove the towel. Officer C was the first officer to respond to Officer B's request and arrived within a further minute. Officer B said that he made the decision to open the door one or two seconds after Officer C arrived.
 47. As Officer B opened the door, he saw Mr Brown hanging from the light fitting. He took hold of Mr Brown across his chest, under his armpits, and cut the ligature with his anti-ligature knife.
 48. While Officer B was cutting the ligature, Officer C used his radio to call a medical emergency code blue. This indicates that a prisoner is unconscious or having breathing difficulties. It also indicates to the control room at the prison that an ambulance needs to be called. The control room recorded the code blue at approximately 7.30am and the ambulance service received a call from Buckley Hall at 7.34am.
 49. Both officers placed Mr Brown onto his bed. After removing the ligature from Mr Brown's neck, they checked for a pulse and tried to gain a response. Officer B said that he could not feel a pulse and he began CPR, while Officer C went to collect a defibrillator from the wing office. Officer D heard the radio call for assistance at approximately 7.25am. He made his way to C wing and said that, on arrival, Officer B was doing chest compressions on Mr Brown.
 50. Officer D said that he could see that Officer B was tiring so he took over administering the chest compressions. Officer C returned with the defibrillator within about two minutes and applied the pads to Mr Brown's chest.
 51. Buckley Hall does not have 24-hour healthcare, and relies on an out of hours medical service. A healthcare assistant (HCA) had arrived for duty in healthcare at 7.25am, and said that she heard the code blue call at 7.30am. She said that she immediately telephoned the control room and informed them that no qualified nurses were on duty yet. (Nursing staff begin their duties at 7.45am daily.) She then attended C wing where she immediately took over chest compressions from Officer D. The defibrillator indicated that there was no shockable rhythm and chest compression continued.
 52. CCTV indicates that staff, including the HCA and Officer D, arrived onto C wing in response to the code blue call within four minutes, and that resuscitation attempts were continuous. Staff rotated resuscitation efforts, until the arrival of paramedics. They arrived at the cell with a nurse (who had arrived for duty at 7.35am and been directed straight to C wing) at 7.44am.

53. The nurse said that paramedics attached their own equipment to Mr Brown, but after completing an electronic trace of his heart, pronounced him dead at 7.45am.

Contact with Brown's family

54. The prison identified Mr Brown's mother as his immediate next of kin. The Deputy Governor, along with the appointed prison family liaison officer (FLO), attended his mother's home that morning. They notified her of her son's death and attempted to answer the immediate questions raised by the family. Mr Brown's mother said that Mr Brown had given her no indication that he was suicidal, and asked whether Mr Brown had left a note, which he had not.
55. The prison offered assistance with funeral costs in line with national guidance. The FLO remained in contact with Mr Brown's family to assist with funeral arrangements and to offer support.

Support for prisoners and staff

56. After Mr Brown's death, the duty Governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
57. The prison posted notices informing other prisoners and staff of Mr Brown's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected.

Post-mortem report

58. The post-mortem has given the cause of death as hanging. Toxicology tests indicated that Mr Brown had not used illicit drugs before his death.

Findings

Roll checks

59. The OSG carried out a roll check on C wing between 6.00 and 6.15am on 14 August. In a statement provided to the police, she said that when conducting a roll check, she would look and listen for movement or breathing, but essentially her job was to confirm the correct number of prisoners. She agreed, when asked, that her check included confirming that prisoners were alive and well.
60. The OSG said that when she reached Mr Brown's cell the observation panel had been blocked by a piece of material hanging on the inside of the door. She did not attempt to gain a response from Mr Brown but said that she heard a noise, which she thought had come from inside the cell. In her police statement, she said that on the evening of 13 August she had not been feeling well. As a result, she conducted her roll check on 14 August more quickly than she would normally have done. She agreed that she should have taken time to gain a response from Mr Brown and that, if she was unable to confirm Mr Brown's well-being visually, she should have reported this to a senior colleague.
61. The OSG has been employed as an OSG in the Prison Service since 4 October 2016. She started her career at HMP Manchester and transferred to Buckley Hall on 18 June 2017. She said that when she started at Manchester she completed a training course for Operational Support Grades, which covered the various tasks she would be expected to complete. Before completing her first night shift on her own at Buckley Hall, she said she shadowed two other OSGs, who showed her what she was expected to do.
62. The guidance set out in the Prison Officer Entry Level Training (POELT) manual states: "Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response, you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead." Although this relates to conducting a roll check, the reasons for checking remain the same when opening a cell door.
63. OSG training is much shorter and covers different areas than that of officer training, but during her interview, the OSG indicated that she was aware that she should have tried to get a visual response from Mr Brown and had failed to do so.
64. The investigator has viewed the CCTV footage of the morning of 14 August, showing the OSG conducting the roll check. It is hard to conclude that she spent sufficient time at any of the cells she checked to have sufficiently confirmed the welfare of the prisoners inside.
65. The OSG's actions on 13/14 August are currently the subject of an internal investigation at Buckley Hall.
66. The investigation is not able to say whether earlier intervention would have prevented Mr Brown's death but, in other cases, correctly carrying out such

routine safety precautions may prevent an ill or dying prisoner going unnoticed in the future. We therefore make the following recommendation:

The Governor of HMP Buckley Hall should review the procedures for roll checks and ensure that, when being carried out, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that require attention

Emergency response

67. Prison Service Instruction (PSI) 03/2013, *Medical Emergency Response Codes*, requires governors to have a medical emergency response code protocol which ensures an ambulance is called automatically in a life-threatening emergency. The protocol should give guidance on efficiently communicating the nature of a medical emergency, ensuring that staff take the correct equipment to the incident and that there are no delays in calling an ambulance. It explicitly states that all prison staff must be made aware of, and understand, the protocol and their responsibilities during medical emergencies.
68. When the two officers entered Mr Brown's cell and realised what had happened, they immediately called an emergency code blue over the radio. According to the control room log, the initial call was received at 7.30am and a call was received by the ambulance service at 7.34am. Prison staff and the healthcare assistant on duty responded quickly to the code and there were no delays in obtaining emergency equipment or with the ambulance service gaining entry to the prison. We make no recommendations.

Assessment of risk

69. Mr Brown had been in custody on a number of occasions, had no significant or recent history of mental illness and had never been subject to self-harm and suicide monitoring. When spoken to on reception by staff or nurses, Mr Brown consistently denied having any intention to self-harm or any thoughts of suicide. He had no history of either in the community.
70. When he arrived at Buckley Hall, there were no indicators or any documented history that suggested that Mr Brown might be at risk. Staff assessed him appropriately and allocated a single cell based on potential risks to others, as had been the case for the majority of his time in prison. We make no recommendations.

Clinical care

71. The clinical reviewer completed a review of Mr Brown's medical care on behalf of NHS England. She has concluded that care received by Mr Brown was of a reasonable standard and was at least equivalent to that which he would have received in the wider community.
72. In summing up her review, the clinical reviewer says that Mr Brown had an earlier history of mental health issues but had not been treated for any issues while in prison. Mr Brown was offered regular assessments and referred to services for mental health and substance abuse support as required, but often did not attend the appointments with these services.

73. Following his transfer to HMP Buckley Hall, Mr Brown received an initial reception screen, but did not attend his full reception screening the next day. He also did not attend a second appointment made for him and therefore did not receive his screening assessment of healthcare needs within 24 hours in accordance with the PSO 3050 'Continuity of Healthcare for Prisoners' (2006).
74. The full health assessment may have provided an opportunity to identify any suicidal thoughts or raise any concerns about his state of mind. This is, though, highly speculative. There were no indications prior to his death that Mr Brown was low in mood or experiencing suicidal thoughts. The clinical reviewer makes a recommendation in her report relating to prisoners' attendance at medical appointments. We would urge the Head of Healthcare at Buckley Hall to consider this recommendation.

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