Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ryan Brennan, a prisoner at HMP Buckley Hall, on 23 August 2022

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

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

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

Mr Ryan Brennan died in hospital on 23 August 2022, after he was found hanging in the segregation unit at HMP Buckley Hall on 20 August, his 40th birthday. This was the first self-inflicted death at Buckley Hall since 2017. I offer my condolences to Mr Brennan's family and friends.

Mr Brennan was clearly struggling in the months before his death, although there were no clear indications why. His risk of suicide dramatically rose in the 24 hours leading to his death and he was subject to suicide and self-harm monitoring procedures. Our investigation found that some aspects of his care could have been managed better.

The clinical reviewer found that aspects of Mr Brennan's clinical care were not equivalent to that which he could have expected to receive in the community.

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

Adrian Usher
Prisons and Probation Ombudsman **October 2023**

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Summary

Events

1. On 24 August 2021, Mr Ryan Brennan was remanded in prison, charged with threatening behaviour and driving offences. Mr Brennan had been in prison twice before, but this was his first time in 12 years.

2. On 22 November, Mr Brennan was sentenced to five years imprisonment. He was moved to HMP Buckley Hall on 25 November.

3. Mr Brennan had a history of substance misuse and mental health issues. Staff monitored Mr Brennan using suicide and self-harm procedures (known as ACCT) on two occasions between January and March 2022, after he self-harmed due to concerns about sharing a cell. After the last period of monitoring, he appeared to settle and was able to share a cell with another prisoner.

4. On 19 August, staff moved Mr Brennan to the segregation unit after he appeared intoxicated and was making threats to other prisoners. He was abusive and aggressive towards members of staff. Mr Brennan broke the glass observation panel of his cell and in the early hours of 20 August (his 40th birthday), he used the broken glass to make cuts to his wrists. Staff started ACCT monitoring with five observations an hour.

5. Mr Brennan self-harmed twice more during the early hours of 20 August, first by cutting and then by tying a sheet around his neck and attaching it to the broken observation panel. He appeared fixated on getting a specific pair of socks brought to him from his cell, but staff told him they were unable to do this. He refused to engage in the ACCT process and was abusive towards staff. Staff continued to monitor him five times an hour. They recorded that he was last checked at 1.45pm.

6. At 1.52pm, staff checked on Mr Brennan and found him hanging from the cell door, having used the broken observation panel as a ligature point. Staff called a medical emergency code. A nurse on the unit responded immediately and started cardiopulmonary resuscitation (CPR) along with two officers. Ambulance staff arrived by 2.05pm and were able to restart Mr Brennan's heart before transferring him to hospital. Mr Brennan never regained consciousness and died in hospital on 23 August.

Findings

7. When Mr Brennan self-harmed in the segregation unit in the early hours of 20 August, staff correctly started ACCT monitoring.

8. When Mr Brennan broke his observation panel, staff did not temporarily repair the damage or record that they had considered moving him to another cell. Mr Brennan was able to use the broken observation panel to self-harm on four occasions, twice to cut himself and twice as a ligature point, the last time proving fatal.

9. CCTV shows that Mr Brennan was last checked at 1.34pm, not 1.45pm as recorded in the ACCT paperwork. The officer responsible for the check has left the Prison Service. Police interviewed her under caution but took no further action.

10. Staff working in the segregation unit told us that they did not feel adequately trained or supported to carry out their duties competently, safely and effectively.

11. The clinical reviewer found that aspects of Mr Brennan's care were not equivalent to that which he could have expected to receive in the community. She found that the service provided by the mental health team was a matter of concern. She made several recommendations as set out in her clinical review report.

Recommendations

- The Governor should ensure that staff:
    - use all the available evidence to assess whether the location of prisoners on ACCT, and the items in their possession, increase the risk of harm, and
    - take necessary steps to reduce the identified risk, as set out in the ACCT guidance.
- The Governor should review the staffing structure and training provided to staff working in the segregation unit to ensure that all staff are confident and competent to safely deal with challenges often experienced in this setting.

The Investigation Process

12. HMPPS notified us of Mr Brennan's death on 24 August 2022.

13. 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 her. One prisoner sent her a letter, and we have included their information in this report.

14. The investigator obtained copies of relevant extracts from Mr Brennan's prison and medical records.

15. NHS England commissioned an independent clinical reviewer to review Mr Brennan's clinical care at the prison. The investigator and clinical reviewer jointly interviewed seven members of staff.

16. We informed HM Coroner for North Manchester of the investigation. The Coroner shared Mr Brennan's post-mortem report with us. We have sent the Coroner a copy of this report.

17. The Ombudsman's family liaison officer contacted Mr Brennan's sister and partner to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Brennan's sister and partner wanted to understand how things had escalated so quickly once Mr Brennan went into the segregation unit and if staff did enough to prevent his death. Mr Brennan's sister also asked if he had left a suicide note and what position he was in when he was found. We have addressed these issues in the report.

18. We shared our initial report with Mr Brennan's sister and partner. They did not raise any factual inaccuracies.

19. We shared our initial report with the Prison Service. The Prison service identified a factual inaccuracy which has been amended within our report.

Background Information

HMP Buckley Hall

20. HMP Buckley Hall is a category C training prison for male prisoners, on the edge of the Pennines, near Rochdale, Lancashire. The prison has four residential blocks and an operational capacity of 459. Spectrum Healthcare provides healthcare services with Greater Manchester Mental Health (GMNH) NHS Foundation providing mental health services. Change Grow Live (CGL) provides drug and alcohol services.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Buckley Hall took place in July 2019. Inspectors reported an excellent inspection, with three out of four of the tests for a healthy prison being awarded the highest standard of 'good'. The only concern was that of purposeful activity. Inspectors noted that prisoners generally felt well supported and had good relationships with staff. While there had been an increase in incidents of self-harm, the level remained low compared to similar prisons. Inspectors reported that 40% of prisoners said it was easy to get drugs in the prison. They noted that while managers had identified drug supply as a main threat to the prison, the response had not been sufficiently robust.

Independent Monitoring Board

22. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to 31 July 2022, the Board reported a safe environment for prisoners with positive and constructive relationships between prisoners and staff. The Board commended the Safer Custody Department for its management of prisoners at risk of suicide and self-harm. The Board described the prison as being relatively calm in terms of violence and noted that incidents of violence were thoroughly investigated. The Board was impressed by the way in which segregation staff managed prisoners in their care.

Previous deaths at HMP Buckley Hall

23. Prior to Mr Brennan's death, there had been no deaths at Buckley Hall since August 2017.

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

25. As part of the process, a care plan (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the care plan 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.

Key Events

Background

26. Mr Ryan Brennan was remanded to HMP Altcourse on 24 August 2021, charged with threatening behaviour and driving offences. Mr Brennan had been in prison twice before, but this was his first time in 12 years.

27. Mr Brennan had a history of substance misuse and mental health issues. He told staff he had tried to take his life in August 2020 and was struggling to cope with the death of his son in 2006. He reported having trouble sleeping and was distressed at having to share a cell.

28. On 22 November, Mr Brennan was sentenced to five years imprisonment.

29. On 25 November, Mr Brennan was moved to HMP Buckley Hall. Staff noted no significant concerns during his reception screening but referred him to the mental health and substance misuse teams for ongoing support. Mr Brennan requested pregabalin (a strong painkiller which is a controlled drug in prison) for his back pain and staff referred him to the GP for further assessment.

30. On 28 November, Mr Brennan had a triage assessment with a mental health nurse. Mr Brennan told her that he thought he had post-traumatic stress disorder (PTSD). The nurse advised him to talk to the GP about this and gave him information about a talking therapy service.

31. On 6 December, Mr Brennan had a triage assessment with a substance misuse worker. He said he wanted to work with the substance misuse team to address cocaine and alcohol misuse. The worker noted that Mr Brennan said he had PTSD and anxiety following the death of his son, but he seemed unsure if he had been taken onto the mental health team's caseload. He noted that he would contact the mental health team and that he would allocate Mr Brennan to a substance misuse worker. (They subsequently saw him regularly and reported no concerns.)

32. On 16 December, Mr Brennan saw the GP, who prescribed amitriptyline (used to treat pain and depression) for his back pain and referred him for physiotherapy. The GP did not prescribe pregabalin as requested, as staff found no evidence that Mr Brennan had been prescribed pregabalin in the past.

33. On 21 December, Mr Brennan pressed his cell bell and asked to be moved from his cell as his cellmate was under the influence of an illicit substance. He told staff that he had already expressed concerns about sharing with this person due to their illicit drug use. Staff agreed to temporarily move Mr Brennan to another cell. However, he refused to return to his cell the following day and staff moved him to the segregation unit for failing to follow orders. He was moved back onto the wing on 24 December.

2022

34. On 3 January 2022, a member of healthcare staff noted in Mr Brennan's medical record that he had failed to attend an appointment with the mental health team. It is not clear when this appointment was made and if Mr Brennan was aware of it.

35. On 5 January, Mr Brennan attended an appointment with a physiotherapist about his back pain.

36. On 13 January, Mr Brennan saw a GP about his back pain. He asked again for pregabalin, but the GP refused and instead increased his dose of amitriptyline. Mr Brennan accepted this treatment.

37. On 18 January, Mr Brennan's partner contacted the prison to express concerns about Mr Brennan's wellbeing. She said that he had been distressed when he called her and said that he was waking up crying in the night. She asked for someone to check on him. A safer custody officer carried out a welfare check the same day. Mr Brennan told the officer that he had been having panic attacks and was wetting his bed. He said he wanted his own cell, but the officer said this would not be possible as there was no reason why he could not share a cell. Mr Brennan said he had previously tried to take his life in the community, but he had no current thoughts of suicide or self-harm. The officer assessed there was no need for suicide and self-harm monitoring (known as ACCT) but said she would contact the mental health team.

38. On 21 January, a mental health nurse noted that staff were unable to support a request for Mr Brennan to have a single cell as he had not had a psychiatric assessment. She said that Mr Brennan had requested mental health input and was on the waiting list for a mental health assessment in the coming weeks.

39. On 27 January, staff again temporarily moved Mr Brennan to another wing due to concerns about his cellmate being under the influence of illicit substances. Later, when Mr Brennan refused to move back to his wing and was abusive towards staff, he was moved to the segregation unit.

40. The following day, Mr Brennan's partner called the prison again to express concerns about Mr Brennan's wellbeing and about his cellmate using illicit substances.

41. On 30 January, a member of healthcare staff made an entry in Mr Brennan's medical record to say that he had failed to attend an appointment with the mental health team.

ACCT – 31 January to 11 February

42. On 31 January, staff started ACCT monitoring after Mr Brennan made cuts to his wrist with a plastic knife after being told he had to return to the wing and share a cell. At his ACCT assessment, he said he was stressed and anxious due to his partner not coping in the community and his children having to live with his mother-in-law. He said that, due to this stress, he felt unable to share a cell.

43. Mr Brennan attended his first ACCT review later that day. He told staff he was being threatened on the wing and needed a single cell. Staff agreed to move him to a different wing but told him he would still have to share a cell. Staff agreed to look into the allegations of bullying.

44. On 2 February, Mr Brennan attended a scheduled mental health appointment with a mental health nurse. He refused counselling and said he continued to struggle with sharing a cell. She suggested a change of medication which he agreed to.

45. By the time of Mr Brennan's next ACCT review on 3 February, he had moved back to the wing and had a cellmate that he was getting along with. He said he was feeling better, that his children had returned to live with his partner, he was planning to change his medication, and he was awaiting a security categorisation review in May.

46. On 11 February, staff stopped ACCT monitoring after Mr Brennan said he was feeling much better and was hoping to transfer to another prison.

14 to 20 February

47. On 14 February, Mr Brennan met with a nurse for a mental health review. She noted that they spoke about his transfer to another prison, and she agreed to liaise with his offender manager about this. She noted no concerns about his mental health.

48. On 16 February, staff told Mr Brennan that he did not meet the criteria for transfer to the prison he requested. Staff noted that he accepted this decision.

ACCT – 21 February to 1 March

49. On 21 February, Mr Brennan punched his cellmate and staff moved him to the segregation unit. The following day, Mr Brennan tied his jumper around his neck and said he wanted to return to the wing. Staff started ACCT monitoring, but Mr Brennan refused to engage with the process. Staff observed him five times an hour (the standard level of observations in the segregation unit up to when the first case review is held).

50. On 23 February, Mr Brennan had a mental health review with a nurse. He said he was unhappy with having too many punishments. He had hoped to see his children, but his partner had been banned from visiting him after they had kissed on her last visit. He said he was not interested in support from the mental health team.

51. Mr Brennan attended an ACCT review on 24 February. He told staff he no longer had thoughts of suicide or self-harm but at the time he tied his jumper around his neck he had wanted to die. He said he was upset because his partner had been banned from visiting him. Staff reduced his observations to three an hour.

52. Mr Brennan later told safer custody staff that he was now willing to share a cell and that he had provoked the attack on his cellmate to try to get a single cell.

53. The following day, Mr Brennan had an ACCT review. He said he was happy to be leaving the segregation unit and he had no thoughts of suicide or self-harm. Staff reduced his observations to one an hour.

54. Staff stopped ACCT monitoring on 1 March. Mr Brennan accepted that he would have to share a cell and said he had no thoughts of suicide or self-harm. The following day Mr Brennan was moved back to a standard wing.

March to August

55. On 12 March, Mr Brennan had a mental health review with a nurse. He asked for a re-referral for counselling to talk about his son's death. He had no other concerns.

56. On 14 May, Mr Brennan was supposed to have an appointment with the mental health team, but said he was asleep and did not want to engage with them. He missed a further appointment on 15 June.

57. On 18 May, Mr Brennan spoke to a safer custody officer about tensions with his cellmate. He said he was worried about his mental health and staff put him on the waiting list to see the mental health team and agreed to move him to another wing.

58. On 19 May, Mr Brennan saw a nurse, who described him as anxious and negative in mood. Mr Brennan said he had no motivation and was not getting on with his cellmate. The nurse did not book a follow up appointment, and this was the last time Mr Brennan saw anyone from the mental health team outside the ACCT process.

59. Mr Brennan received a number of negative behaviour entries for failing to attend work or education, saying that this was because of his mental health issues and problems with other prisoners. Staff were initially understanding but eventually moved him onto basic regime on 20 June, due to his non-attendance. Mr Brennan then made some efforts to engage with work and staff praised his efforts, moving him back onto standard regime. However, he soon slipped back to missing work, often because he would not get out of bed despite staff waking him, and he received more negative behaviour entries as a result.

60. On 14 July, Mr Brennan's partner contacted the prison to say she needed his support in relation to issues with their children. Staff arranged a compassionate call. However, Mr Brennan's behaviour continued to deteriorate.

61. On 18 August, Mr Brennan demanded to go to the segregation unit and became abusive towards staff and prisoners. Staff placed him on basic regime again due to his behaviour.

Events of 19-20 August

62. On 19 August, Mr Brennan began making threats towards other prisoners. Staff noticed he had a cut above his eye, grazing to his face and appeared intoxicated. He said he had walked into a wall. Staff moved him to the segregation unit at around 5.40pm.

63. Shortly after 6.30pm, a nurse went to Mr Brennan's cell to check his injuries and to assess whether he was medically fit for segregation. She described him as having a black eye. He said he was fine but asked for paracetamol but, as officers thought he was intoxicated, she did not give him any medication. She did not consider that he was under the influence of alcohol or any illicit substances, therefore she said she did not think it necessary to take any further observations or carry out any assessment. She completed the healthcare algorithm and concluded that Mr Brennan was medically fit for segregation. She signed the form at 6.45pm. She then left the prison for the evening.

64. The Head of Safer Custody was the duty governor, and he signed the necessary documentation authorising Mr Brennan's segregation before leaving the prison at around 7.00pm. He said that, as duty governor, he would have expected the night orderly officer (the senior officer in charge at night) to contact him if there were any significant changes in Mr Brennan's circumstances during the night. However, he was not contacted by anyone at the prison during the night.

65. Shortly after 8.00pm, Mr Brennan broke the glass observation panel in his cell door by hitting it repeatedly. He continuously demanded specific socks be collected from his property and brought to him in the segregation unit, but staff told him they were unable to do this.

66. At approximately 2.00am on 20 August (his 40th birthday), Mr Brennan used the glass from the broken observation panel to make cuts to his wrists, and staff started ACCT monitoring with five observations an hour. The ACCT documentation was not fully completed so it is not clear exactly what time monitoring started.

67. The night orderly officer completed the immediate action plan. However, he did not inform the duty governor, and so they did not authorise Mr Brennan's continued segregation while on an ACCT (known as the Defensible Decision Log, which is required by the national policy).

68. Mr Brennan made further cuts to his wrist at around 3.30am. Mr Brennan did not receive any medical attention as the prison does not have 24-hour healthcare. Staff later removed the glass from his cell to prevent further injury.

69. At around 4.00am, Mr Brennan wrapped a sheet around the broken observation panel and tied it around his neck. He said he did this because staff would not give him the specific pair of socks from his property, and he continued to be abusive towards staff. Staff removed the bed sheet from the cell and continued to monitor him five times an hour.

70. At around 10.15am, an officer tried to engage with Mr Brennan to complete his ACCT assessment. Mr Brennan told her he did not want to speak to her, so she completed the assessment based on information obtained from various prison records. She wrote that she was unable to explore risk issues with him as he was not willing to engage with her. Staff continued to monitor him five times an hour.

71. Mr Brennan attended his first ACCT case review at around 12.00pm. A nurse from the mental health team attended. The Head of Safer Custody also attended due to Mr Brennan being monitored on an ACCT while in the segregation unit. Mr Brennan became abusive when staff told him he would be held in segregation over the weekend pending an adjudication the following Monday. He walked out shortly afterwards and, while an officer was walking him back to his cell, he said "I might as well kill myself". She returned to the meeting and told staff what he had said. Staff agreed to continue to monitor him five times an hour on the basis that the first ACCT case review had not yet taken place as he had not engaged. Staff agreed that Mr Brennan's case should be referred to the Safety Intervention Meeting (SIM) and arranged the next review for the following day.

72. ACCT observation records show that Mr Brennan was checked by staff at 1.00pm, 1.15pm, 1.19pm, 1.40pm and 1.45pm. CCTV confirms the first three checks but shows that Mr Brennan was last checked by an officer at 1.34pm.

73. At 1.52pm, the officer found Mr Brennan in a sitting position behind the cell door with a ligature tied to his neck. He had tied a sheet to the broken observation panel. She called for help, and her colleague immediately called a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties). A nurse was already on the segregation unit, so she responded immediately and started cardiopulmonary resuscitation (CPR) with the assistance of both officers. Ambulance staff arrived by 2.05pm and were able to resuscitate Mr Brennan before transferring him to hospital. Mr Brennan never regained consciousness and died in hospital on 23 August.

Information received after Mr Brennan's death

74. Mr Brennan made a number of telephone calls before his death, including calls to his partner during which he was angry and abusive towards her. It was clear from some of these calls that Mr Brennan was involved in some level of drug supply within the prison and that the socks he was demanding most likely contained drugs. The socks were never recovered.

75. The prisoner in the cell opposite Mr Brennan's wrote to the investigator to say that Mr Brennan had been very disruptive throughout the night, and he had tried to get him to calm down. He said that he could hear some of Mr Brennan's telephone conversations which were very heated and of a personal nature. The prisoner wrote that staff tried their best to support Mr Brennan and shortly before he was found hanging, an officer had been trying to talk to him and offered to get him some hot water to make a drink.

76. Mr Brennan did not leave a suicide note.

Contact with Mr Brennan's family

77. Mr Brennan's family were present at the hospital when he died. The prison offered a contribution to Mr Brennan's funeral expenses in line with national policy and stayed in contact with his next of kin.

Support for prisoners and staff

78. After Mr Brennan's death, a prison manager debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

79. Some staff involved in events leading up to Mr Brennan's death were suspended, pending an internal investigation. Those that we spoke to were concerned about the way they had been treated and how this was communicated to them by prison managers. All staff eventually returned to work following the investigation, although one officer subsequently left the Prison Service.

80. The prison posted notices informing other prisoners of Mr Brennan's death and offering support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Brennan's death.

Post-mortem report

81. The pathologist concluded that Mr Brennan died as a result of a hypoxic-ischaemic brain injury caused by pressure to the neck. The pathologist noted some injuries that may have been consistent with an assault some days prior to Mr Brennan's death. Samples taken from Mr Brennan's body showed the presence of various types of illicit medication, including pregabalin, which were not prescribed to Mr Brennan.

Findings

Assessment and management of risk

82. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), sets out the procedures (known as ACCT) that staff must follow when they identify that a prisoner is at risk of suicide and self-harm.

83. We are satisfied that staff in the segregation unit took the necessary action to start ACCT monitoring when Mr Brennan self-harmed. However, we found that staff did not take adequate precautions to ensure that he could not harm himself further. He used the broken observation panel to self-harm on four occasions, twice to cut himself and twice as a ligature point, including the last occasion which resulted in his death. While staff removed some of the items Mr Brennan had used to harm himself (the broken glass and one sheet), they did not apparently consider moving him to a new cell or risk assess the items remaining in his cell.

84. The Head of Safer Custody, the duty governor, said there was an available cell in the segregation unit that Mr Brennan could have been moved to but there would have been security considerations in attempting to move him during the night. While we understand these challenges, we found no evidence in the ACCT document that staff recognised the risk posed by the damaged observation panel or that an alternative cell was considered at any time. We make the following recommendation:

    The Governor should ensure that staff:

    - **use all the available evidence to assess whether the location of prisoners on ACCT, and the items in their possession, increase the risk of harm, and**

    - **take necessary steps to reduce the identified risk, as set out in the ACCT guidance.**

85. The ACCT paperwork says that Mr Brennan was checked at 1.40pm and 1.45pm on 20 August. However, CCTV shows that he was last checked at 1.34pm, 18 minutes before he was found hanging. One officer no longer works for the Prison Service, and we did not interview her. The police interviewed her under caution. She told the police that she was not always able to record checks as soon as she did them as she was frequently busy and distracted by other prisoners. She denied deliberately falsifying the time of the check and suggested the discrepancy may have been caused by her watch showing an incorrect time. The police took no further action. Had this officer still been working for the Prison Service, we would have recommended an internal investigation.

86. The Head of Safer Custody told the investigator that the prison has a quality assurance process in place to check that ACCT observations and conversations take place at the required frequency.

Staffing on the segregation unit

87. We heard from some members of staff that the segregation unit was often short staffed. The unit requires staff to have specific training and, if those trained members of staff were unavailable, other members of staff were asked to cover, sometimes at short notice. Some staff felt that the training they received was insufficient.

88. Over the weekend of Mr Brennan's death, only one of the staff rostered to work in the segregation unit had received the necessary training; all of the other staff on duty in the segregation unit had been moved from other parts of the prison. On the afternoon of 20 August, we were told that none of the staff on duty were trained to work in the segregation unit and the only trained member of staff had finished for the day. We recommend:

    The Governor should review the staffing structure and training provided to staff working in the segregation unit to ensure that all staff are confident and competent to safely deal with the challenges often experienced in this setting.

Clinical care

89. The clinical reviewer concluded that some of the clinical care Mr Brennan received was not equivalent to that which he could have expected to receive in the community. She found that the service provided by the mental health team was a matter of concern. Mr Brennan was not assessed for six to seven weeks following his initial referral, due to staff sickness within the mental health team. The clinical reviewer has made separate recommendations in her clinical review report which the Head of Healthcare will want to action.

Governor to Note

Early Learning Review

90. After Mr Brennan's death, HMPPS undertook an Early Learning Review to identify any immediate lessons to be learnt. The Review identified some omissions in the completion of documentation and the recording of decision making by staff involved in Mr Brennan's ACCT including that:

    - The duty governor did not complete a Defensible Decision Log to authorise Mr Brennan's continued segregation while on an ACCT.

    - Staff did not record whether they considered placing Mr Brennan under constant supervision (rather than five checks an hour) when he said he 'might as well kill himself' on 20 August.

91. The Review made a series of recommendations to the Governor, which were accepted with details of the actions taken in response. As a result, we have not repeated the issues or made recommendations in this report.

Defibrillators

92. During the course of the investigation, we found that there was only one working defibrillator in the prison, which was held by healthcare staff. Although this had no impact on the outcome for Mr Brennan, it could be crucial in a future medical emergency, especially as the prison does not have 24-hour healthcare. The Governor and Head of Healthcare should ensure that working defibrillators are available throughout the prison as a matter of urgency.

Inquest

93. The inquest, held from 15 to 26 January 2024, concluded that Mr Brennan took his own life by means of self-ligature but it was unclear whether his intention was to end his life. The jury concluded that the failure in the awareness and removal of the broken observation panel more than minimally contributed to Mr Brennan's death.

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