

**Prisons &
Probation**

Ombudsman
Independent Investigations

**Independent investigation into
the death of Ms Leona Burn,
a prisoner at HMP/YOI
Downview, on 3 March 2017**

A report by the Prisons and Probation Ombudsman

OUR VISION

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

WHAT WE DO



WHAT WE VALUE



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

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.

Ms Burn was found hanging in her room at HMP Downview on 2 March 2017. She was taken to hospital but died on 3 March. She was 34 years old. I offer my condolences to Ms Burn's family and friends.

Ms Burn was being managed under suicide and self-harm procedures, known as ACCT, on the day she hanged herself. Although she had appropriately been assessed as posing a high risk to herself, the investigation found a number of weaknesses in the way Downview responded to this risk. I am particularly concerned that although Ms Burn's anxiety about her medication was one of her key risk factors, no one from healthcare participated in the ACCT process and the GP who saw Ms Burn to review her medication on the day she hanged her did not even know she was being managed under ACCT.

I am also very concerned that, although Ms Burn was assessed as a high risk to herself, three staff took no action when they saw her with a possible ligature in her room on the morning of 2 March 2017.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman

February 2023

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Summary

Events

1. On 19 July 2016, Ms Leona Burn was sentenced to 140 days imprisonment for theft and breach of a supervision order. She was taken to HMP Eastwood Park.
2. Ms Burn had a long history of substance abuse. She had been prescribed clonazepam medication for epilepsy and back pain in the community, and this was continued in prison. She was allocated a single room as she was assessed as a high risk of harm to others.
3. In August 2016, she was placed on the basic regime for fighting, which meant that her television was removed. She said she would kill herself if her television was not returned and was managed under suicide and self-harm procedures, known as ACCT.
4. In October, Ms Burn received an additional sentence of 14 months. She was transferred to HMP Downview on 22 November.
5. On 27 November, Ms Burn was placed on the basic regime for 28 days because of poor behaviour. This meant her television was automatically removed.
6. In January 2017, the GP practice began slowly reducing Ms Burn's clonazepam as there was no evidence that she had a formal diagnosis of epilepsy. Ms Burn was very unhappy about this.
7. On 25 February, Ms Burn was placed on the basic regime for 28 days after fighting with another prisoner. She said she would not be able to sleep at night without a television and that this would exacerbate her epilepsy. She said she would hang herself because she could not cope with fits. Staff started ACCT procedures. Ms Burn was assessed as being at high risk of suicide and she was observed twice an hour. She was allowed to have a television at night to help her sleep, to be returned during the day.
8. On 28 February, Ms Burn complained to an officer that her back pain was making her feel suicidal, and said she had obtained some prescription medication illicitly from another prisoner.
9. On the morning of 2 March, Ms Burn refused to return her television, as agreed. At 9.50am, she refused to return to her room after seeing a GP and was escorted back by several officers. Ms Burn told the officers to wait and see what would happen next. She wrapped herself in a curtain so staff could not see her. Staff had an informal discussion and decided that Ms Burn would no longer be allowed her television over night as she was not following the rules. They noticed that Ms Burn had a length of fabric hanging in her room but did not ask her to hand it to them.
10. An officer checked Ms Burn at 12.20pm and saw her sitting on her bed. At 12.46pm, another officer looked into Ms Burn's room and saw her hanging from a ligature attached to electrical pipes fixed to the wall. The officer radioed an emergency medical code for assistance. Staff began CPR, paramedics arrived and detected

signs of life. Ms Burn was taken to hospital at 1.55pm by ambulance but died on 3 March at 8.15pm.

Findings

Risk assessment and management of ACCT

11. The identification and management of prisoners at risk of suicide and/or self-harm is everyone's responsibility. We are concerned that healthcare staff did not consider opening ACCT procedures on two occasions in early 2017.
12. Although the ACCT assessment on 25 February 2017 was commendably thorough, we are concerned that there was no healthcare input into the subsequent ACCT review. We consider this was a significant omission as Ms Burn's concern about her medication was a key risk factor for her.
13. Although Ms Burn's level of risk was appropriately assessed as high on 25 February, we are concerned that there was too long a gap – a week - before the next scheduled case review and that this did not adequately reflect Ms Burn's level of risk.
14. We consider that Ms Burn's behaviour on 2 March should have prompted an ACCT case review.
15. We are concerned that, although it had previously been agreed that Ms Burn could have a television overnight to help her sleep, staff decided informally to remove the television on 2 March, outside the ACCT process and without considering how this might affect her risk.
16. We are very concerned that, although Ms Burn was on an ACCT, assessed as a high risk to herself, and locked in her room in a distressed state, three staff took no action when they saw her with a possible ligature in her room on the morning of 2 March.

Clinical Care

17. We are concerned that the nurse who conducted Ms Burn's initial health screen at Downview did so without reading information about her risk of suicide or self-harm.
18. Ms Burn had good access to primary care nurses and appropriate access to a GP when required and was readily able to access the substance misuse team, which kept comprehensive notes and shared information with other staff. The management of her substance misuse was in keeping with recommended guidelines on maintaining a stable rather than a reducing dose of methadone.
19. The clinical reviewer concluded that, although some of Ms Burn's clinical care was of a very high standard, the lack of healthcare input into the ACCT procedures meant that her care was not equivalent to that which she could have expected to receive in the community.

Recommendations

- The Head of Healthcare should remind all healthcare staff, including GPs, they have a responsibility to open ACCT procedures if they consider a prisoner is at risk of suicide or self-harm.
- The Governor and Head of Healthcare should ensure that the ACCT document accompanies prisoners when they move around the prison, including to healthcare appointments.
- The Governor and the Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including in particular that:
 - Mental health staff attend or contribute to all ACCT reviews for prisoners in their care and are fully involved in decisions about their level of risk.
 - A member of healthcare staff should attend all case reviews and subsequent reviews where relevant.
 - Case reviews assess the risk of suicide or self-harm based on all available information and known risk factors and set a level of observations which reflects that risk.
 - Staff review risk and consider whether to hold a case review whenever an event occurs which indicates an increase in risk.
- The Governor should consider initiating an investigation into the actions of SO A and Officers B and C in relation to the piece of fabric they saw in Ms Burn's room on 2 March 2017, with a view to considering whether disciplinary action is appropriate.
- The Governor should share this report with Officer A, SO B, a senior manager and CM A and arrange for a senior manager to discuss it with them to ensure they are aware of the Ombudsman's findings.
- The Governor and Head of Healthcare should ensure that nurses conducting reception health screenings always have access to the PER and have time to read it.

The Investigation Process

20. The investigator issued notices to staff and prisoners at HMP Downview informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
21. The investigator visited Downview on 9 March 2017. She obtained copies of Ms Burn's prison and medical records.
22. NHS England commissioned a clinical reviewer to review Ms Burn's clinical care at the prison. The investigator and clinical reviewer conducted seven joint interviews.
23. The investigator interviewed 18 members of staff and two prisoners at Downview between May and June 2017. She then provided feedback to the then Governor that three members of staff were aware of a ligature in Ms Burn's room on 2 March 2017 but did not take steps to remove it and could not explain their actions satisfactorily.
24. We suspended our investigation in July 2017 at the request of Surrey police, who conducted a criminal investigation. The Crown Prosecution Service decided there was sufficient evidence to charge three prison officers with gross negligence manslaughter. A trial took place in July and August 2019. The officers were found not guilty.
25. We informed HM Coroner for Surrey of our investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
26. We contacted Ms Burn's family to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Ms Burn's mother asked why she was in a single room and why she was not watched more closely when Downview knew she was at risk of suicide. We have addressed these questions in this report.
27. We shared our initial report with HM Prison and Probation Service (HMPPS). They did not identify any factual inaccuracies. We amended the wording of one recommendation.

Background Information

HMP Downview

28. HMP Downview was opened in 1993 as a low security prison for adult men. In 2001 it became a prison for sentenced adult women until October 2013 when it closed. After extensive refurbishment, Downview re-opened in May 2016 as a women's prison. It currently holds up to 359 women, almost all in single rooms. The first night and induction unit, A wing, where Ms Burn was located, can accommodate up to 44 prisoners.

HM Inspectorate of Prisons

29. The most recent inspection of HMP Downview was in August 2017. Inspectors reported that levels of self-harm were low. Many women spoke positively of the support they had received from staff in times of crisis. Most were able to identify a member of staff they could speak with if they had a problem and told inspectors that staff knew about issues and concerns that affected them.

Independent Monitoring Board

30. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its most recent annual report for the year to April 2018, the IMB reported that the standard of healthcare was consistently very good, wing staff knew the women in their care and made particular note of women they considered to be more vulnerable.

Previous deaths at HMP Downview

31. Ms Burn's was the first self-inflicted death at Downview since 2013. Since Ms Burns' death, there have been two self-inflicted deaths (in April and August 2018). In one of these deaths, we found that the woman had been on basic IEP.

Assessment, Care in Custody and Teamwork

32. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner.
33. 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 made at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap (a plan of care, support and intervention) to identify the prisoner's most urgent issues and how they will be met. There should be regular multi-disciplinary

case reviews involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

34. On 19 July 2016, Ms Leona Burn was sentenced to 140 days imprisonment for theft and breach of a supervision order. She was taken to HMP Eastwood Park. It was not her first time in custody.

HMP Eastwood Park

35. Ms Burn was assessed on reception by a healthcare assistant as having a longstanding history of substance misuse, including heroin addiction, back pain, nerve damage to her hand, and epilepsy (although the latter was not formally diagnosed). She also had a history of self-harm and was recorded to have self-harmed with a ligature in 2006. Ms Burn said she did not have plans or thoughts of self-harm. Her Cell Sharing Risk Assessment (CSRA) level found she posed a high risk of harm to other prisoners, and she was, therefore, allocated a single room. She also had a history of assaults on staff and racist comments.
36. A urine test was positive for opiates, and she was referred to the substance misuse service. A substance misuse clinician arranged for her to have detoxification treatment. She completed the detoxification course on 26 July.
37. In August, Ms Burn was reduced from standard to basic under the Incentives and Earned Privileges (IEP) scheme following a fight with another prisoner. This meant that she would be on a restricted regime and lose access to some facilities, including a television in her room. (The IEP scheme aims to encourage and reward responsible behaviour. There are three levels: basic, standard and enhanced.) The following day, Ms Burn told an officer that she would kill herself if her television was not returned. ACCT procedures were opened. Ms Burn's risk of harm to self was assessed as low.
38. A few days later, Ms Burn had a disciplinary hearing in relation to the fight with the other prisoner and was given seven days cellular confinement in the segregation unit. The ACCT case manager met with Ms Burn and decided to close the ACCT document. He did not record his reasons. At the end of August, a prison manager decided to allow Ms Burn to have a television at night because she appeared to be struggling.
39. On 20 October, Ms Burn received a 14 month sentence for further offences. She was due to be released on 15 May 2017.

HMP Downview

40. On 22 November 2016, Ms Burn was transferred to HMP Downview. As part of the Person Escort (PER) that accompanies a prisoner when they move from one location to another, a 'suicide/self-harm warning form' was completed for Ms Burn. It highlighted that Ms Burn had a history of self-harm in the community and that she had stated she was concealing razor blades and "would cut up any officer in her way". As a result, it was decided that Ms Burn would be handcuffed for the journey and her shoelaces were removed to prevent any potential self-harm.

41. When Ms Burn arrived at Downview, a nurse carried out an initial health screen. She recorded that Ms Burn had epilepsy and back pain and a history of drug misuse, including the use of intravenous heroin, amphetamines and benzodiazepines (sedatives), and was prescribed methadone (a heroin substitute) and clonazepam (a benzodiazepine). She also recorded, incorrectly, that there were no concerns about self-harm or suicidal intent and that Ms Burn had not tried to harm herself in prison or in the community.
42. On the same day, Ms Burn was seen by another nurse from the substance misuse team, who re-prescribed her methadone.
43. Ms Burn told a chaplaincy worker that she was not happy about being at Downview and was worried about her epilepsy medication (clonazepam).
44. On 27 November, an officer, placed Ms Burn on a disciplinary charge after seeing another prisoner hand her a white powdery substance. Custodial Manager (CM) A chaired an IEP review and Ms Burn, and the other prisoner were both given 28 days on the basic regime.
45. On 30 November, Ms Burn was seen by a worker from the substance misuse team. He recorded that, as Ms Burn was due to be released in less than 26 weeks, she should be maintained on a maintenance dose of methadone. He also recorded that Ms Burn told him she was prescribed clonazepam for epilepsy and that she became “defensive” when he asked questions about this.
46. On 15 December, a prison GP reviewed Ms Burn’s records in response to a request to renew her prescription for clonazepam. He noted that she had not attended appointments with a neurologist to confirm a diagnosis of epilepsy and he queried whether she was on clonazepam for epilepsy or whether she was benzodiazepine-dependant. He asked that she be booked in for a GP review and queried whether her clonazepam should be slowly reduced. (Clonazepam is not a usual first or second line treatment for epilepsy. Like other benzodiazepines it is widely misused as a drug of addiction as it has a calming and hypnotic effect. The British National Formulary says that benzodiazepines should not be prescribed for long periods and should be discontinued as soon as feasible. However, sudden withdrawal may cause side effects, including insomnia, and benzodiazepine withdrawal should, therefore, be carried out at a rate that is tolerable for the patient and may take several months or more for long-term users.)
47. On 18 December, a SO (Supervising Officer) chaired an IEP review. Ms Burn said that she felt aggrieved because she had learnt that the prisoner who had passed her the substance was no longer on basic. Ms Burn said she had appealed but the custodial manager had not given her an answer. She swore at the SO.
48. On 21 December, a prison manager told Ms Burn that if her behaviour remained acceptable, she could have a television and association from 24 to 28 December.
49. A prison GP booked four appointments for Ms Burn to discuss her medication, but Ms Burn did not attend any of them. He arranged for a very slow reduction in clonazepam from 16 January 2017.

50. On 19 January, Ms Burn complained to a nurse that her dose of clonazepam had been reduced. The nurse told her to discuss her concerns directly with a GP. Ms Burn saw a GP on 20 January. He recorded that Ms Burn was “very anxious and suicidal due to her worries about her medication, etc”. He told her that proof would be needed from her community GP to continue prescribing her the medication. He asked the healthcare administrator to write to Ms Burn’s GP requesting confirmation of her diagnosis and current medication.
51. On 26 January, Ms Burn told a nurse that she was unhappy with the clonazepam reduction and had not been aware of it before. The nurse said that the GP had discussed it with her at their last consultation. She recorded that an officer told her that Ms Burn was unhappy with her medication and that she said that the GP was due to see Ms Burn again on 3 February.
52. The GP saw Ms Burn again on 3 February. Ms Burn said she felt her clonazepam was being reduced too quickly, and the GP agreed to slow down the reduction. The GP also prescribed her co-codamol (a painkiller) for her back pain. She recorded that Ms Burn was happy with this.
53. On 9 February, a prison GP reviewed Ms Burn’s records and noted that the clonazepam may have been reduced more quickly than intended. He corrected the error and asked another GP to review the dosages the next day.
54. On the same day, Ms Burn met with a worker from the substance misuse team. Ms Burn appeared stressed and said that the reduction of clonazepam was the source of her stress and anxiety. She said she was not sleeping and was afraid she might have an unwitnessed seizure. She also said she would revert to injecting heroin again when she was released in order to self-medicate as she was not being prescribed the correct medication. She became tearful and said she felt under pressure to be ‘clean’ for her children and that she “did not want to leave them without a mother”. The worker made a note in the staff observation book so that officers would be aware. She planned to see Ms Burn again on 16 March.
55. On 17 February, Ms Burn saw a nurse. She said the co-codamol was not working for her back pain and asked to be prescribed pregabalin, which she said previously helped with her anxiety as well. (Pregabalin is used to treat nerve pain, epilepsy and anxiety, but is also widely misused and traded in prison.) The nurse advised Ms Burn to continue using her current medication and told her she would be placed on the waiting list to see the GP about her medication.
56. On 22 February, Ms Burn saw a prison manager and they discussed her plans for her release in May. Ms Burn felt she would be vulnerable to using drugs again in the community and said she was likely to return to her partner, who was an illicit drug user.
57. On 23 February, a prison GP reviewed Ms Burn’s records and identified that the planned reduction in clonazepam had not happened. He advised a step down that day and again in two weeks.

Events of 25 February 2017

58. At 9.30am, on 25 February, Ms Burn was involved in a fight with a prisoner from another wing while collecting her methadone. SO A chaired an IEP review with Ms Burn and Officer A present, and decided that Ms Burn should be placed on the basic regime for 28 days. Her television was therefore removed from her room. Ms Burn was very unhappy with the outcome and argued that staff should have prevented the fight because they knew there had been issues between her and the other prisoner before.

59. At 11.00am, Ms Burn told Officer A that she would not be able to sleep at night without a television and would have fits. She said she would hang herself because she would not be able to cope with the fits. The officer started ACCT procedures and the level of observations was set at twice an hour.

At 2.30pm Ms Burn had an ACCT assessment interview with SO B. She said that the incident with the other prisoner and being placed on basic had contributed to how she was feeling, though she had been feeling low for about three days and had not been sleeping well. She said that she was feeling overwhelmed because she did not have any external support, was still grieving for her father, had nowhere to live on release, had suffered domestic violence from her partner, and was not allowed contact with her three children who were all in care because of her drug use. Ms Burn said that she did not want to be alive, had nothing to live for and if she had the opportunity, she would hang herself. She said she would not be able to cope without a television and was 'adamant' that she would hang herself. The frequency of observations was set at twice an hour, and it was decided that Ms Burn would see a GP to discuss her sleep problems, be referred for grief counselling and would continue to receive support from the substance misuse team.

60. A case review took place immediately after the assessment. No healthcare staff were invited to take part. No one from the mental health team was able to attend because they only worked on weekdays and the ACCT review took place on a Saturday. Ms Burn's risk to herself was assessed as high. The duty governor allowed Ms Burn to have a television at night but it had to be returned to the staff office in the morning. It was recorded that Ms Burn was "a little less stressed out" as a result. The next ACCT review was set for 3 March, with a request for a member of the substance misuse team to attend. The frequency of observations remained at twice an hour with the additional component of three conversations a day.

61. On 28 February, Nurse A from the mental health in-reach team visited Ms Burn on A wing at the request of the visiting psychiatrist. She told the investigator that she had not met Ms Burn before this. She said Ms Burn was very angry, distressed and not willing to talk about her mental health. She complained she was experiencing intense back pain and said she would "not go behind her door" (that is, would not allow staff to lock her in her room) unless a GP prescribed her pregabalin and clonazepam. She expressed thoughts of self-harm and said she "would act on them" if she did not get her medication reinstated by a GP. She complained of severe pain in her neck and back. She expressed anxiety but refused to elaborate. She only wanted to talk about her medication. The nurse noted that Ms Burn was not psychotic (that is, she was not out of touch with reality). She spoke to Nurse B from the primary care team and arranged for her to see Ms Burn later that day.

62. Nurse A told the investigator that she did not believe Ms Burn to be at immediate risk to herself and she did not, therefore, request an urgent ACCT case review. She did however inform Officer B that Ms Burn was distressed and would not settle. She planned to return to see Ms Burn for a mental health assessment on 2 March when she was next on duty.
63. Also on 28 February, Officer B recorded that Ms Burn had told her that she had traded some tobacco with another prisoner for some pregabalin, and that she said she could not go behind her door because the pain made her suicidal. The officer submitted an intelligence report and made a note in the wing observation book.
64. Nurse B saw Ms Burn and told her to take co-codamol for her back pain and also gave her ibuprofen (an anti-inflammatory). She referred Ms Burn for a pain-relief review with a GP. Ms Burn threatened to kill herself that night so as not to experience the pain she was having. She noted that Ms Burn had not complained of any pain when she had seen her earlier in the day and that she was not limping when she walked.
65. Nurse B concluded that Ms Burn was already on an ACCT, which meant she would be checked twice per hour. She told the investigator that she did not add any notes in the ACCT as she was happy with this level of observations.
66. On 1 March, Ms Burn said she was not feeling any better despite taking the medication. A nurse recorded that Ms Burn had no suicidal thoughts and booked a GP appointment for the next day.

Events of 2 March

67. On the morning of 2 March, Ms Burn refused to hand in her television as agreed.
68. At 9.46am she had an appointment with a prison GP. He wrote in her clinical record that she was “very rude” and moaned about the clonazepam reduction and her back pain. He offered to prescribe her naproxen, a prescription only anti-inflammatory drug, but Ms Burn said it did not work. He advised her that she needed to try it. He refused to prescribe her pregabalin. He told the investigator that he did not know that Ms Burn was being managed under ACCT procedures.
69. Ms Burn returned to A wing at 9.50am in an angry mood and sat in the association area even though she should have been locked in her room because she was still on the basic level of the IEP scheme. She shouted at the officers that she would not be locked in her room and remained sitting on the sofa. Staff used ‘minimal force’ to get her up off the sofa and escorted her to her room. She said to the officers, “Watch what I do behind my door”, and went in.
70. Officer C looked into Ms Burn’s room shortly afterwards but could not see her. Ms Burn had wrapped herself in the privacy curtain and would not answer when Officer C and Officer B knocked on her door. Officer C radioed for staff assistance. Ms Burn shouted that she was alright and wanted to be left alone.
71. A senior manager, CM A, SO A, Officer C and Officer B then held an informal discussion of Ms Burn’s behaviour that morning in the staff office and concluded that the rules for prisoners subject to the basic level of the IEP scheme needed to

be clearer. They did not consider increasing the frequency of ACCT observations for Ms Burn and decided she would no longer be allowed her television overnight because she was not complying with the rules. In the meantime, Nurse A arrived on A wing to see Ms Burn but, after seeing the managers in the staff office, she decided she would return in the afternoon.

72. At 11.15am, Officer C wrote in Ms Burn's ACCT document "noose has been removed from ceiling". She told the investigator that she had seen a piece of bedsheet hanging from above where Ms Burn's television would have been. She could not explain why she had used the term 'noose'. She could not say whether there was a loop at the end and thought it might have been where the fabric was hanging that made her associate it with that word. She did not ask Ms Burn what it was and when she checked on her again, the fabric had been removed. She did not ask Ms Burn where it was.
73. Officer B told the investigator she saw a piece of green material hanging along the vertical pipes alongside the wall in Ms Burn's room. She did not recall mentioning it to Officer C, although Officer C said that Officer B told her about it. She said she did not ask Ms Burn what it was or why it was there. Officer B told SO A.
74. SO A told the investigator that after the officers mentioned the fabric, he spoke to Ms Burn through the hatch in her door for about five minutes. He said she had a piece of bedding in her hand. She was pulling it with her hands, and he interpreted it as a kind of 'stress reliever'. He did not speak to Ms Burn about the fabric and did not feel that the frequency of observations needed to be increased.
75. A prisoner told the investigator that Ms Burn told her that she had tied two sheets together and would hang herself to get out of the prison one way or another.
76. Ms Burn was last seen alive at 12.20pm by Officer B, who said she saw her sitting on her bed. Officer D was patrolling A wing at lunchtime. She opened Ms Burn's door flap at 12:46pm and saw her hanging from a ligature made from a green sheet. She radioed an emergency medical code blue, and an ambulance was called. Officer A went into the room with Officer D, cut the ligature from the pipe and from Ms Burn's neck and checked for a pulse. Another officer began CPR. A physical education instructor took over chest compressions from the officer until paramedics arrived. A defibrillator was used but no shock was advised. At 1.22pm, a pulse was found.
77. Ms Burn was taken to hospital but did not regain consciousness. At 8.15pm on 3 March, it was confirmed that Ms Burn had died.

Contact with Ms Burn's family

78. Ms Burns and her family members lived in Wales. A chaplain from the prison's chaplaincy team telephoned Ms Burn's mother to inform her that her daughter was in hospital. Ms Burn's mother, stepfather, sister and partner drove to the hospital and met with the chaplain and the prison's family liaison officer. Arrangements were made for Ms Burn's children, who were in care, to see her.
79. The prison contributed to the cost of Ms Burn's funeral, in line with national policy.

Support for prisoners and staff

80. After Ms Burn's death, the Governor debriefed the staff involved in the emergency to ensure they had the opportunity to discuss any issues arising and to offer support. The staff care team also offered support.
81. The prison posted notices informing other prisoners of Ms Burn's death and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm in case they had been adversely affected by Ms Burn's death. A memorial service was held, and Ms Burn's friends gave several cards to her family members when they visited.

Post-mortem report

82. The post-mortem examination gave Ms Burn's cause of death as hypoxic brain injury (damage to the brain due to lack of oxygen).

Events after Ms Burn's death

83. In November 2018, SO A and Officers B and C were charged with gross negligence manslaughter for failing to remove the 'noose'. A trial took place in July/August 2019 and the officers were found not guilty.

Findings

Assessment of risk

84. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), gives guidance to staff on how to identify, manage and support prisoners who are at risk of harm to themselves or others. It sets out the procedures (known as ACCT) that must be followed whenever staff assess that a prisoner is at risk of suicide or self-harm and requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. Any prisoner identified as being at risk of suicide or self-harm must be managed under ACCT procedures.
85. The PSI says that “the identification and management of prisoners at risk of suicide and/or self-harm is everyone’s responsibility” and that “any member of staff who receives information, including that from family members or external agencies, or observes behaviour which may indicate a risk of suicide/self-harm must open an ACCT”.
86. We are concerned that healthcare staff did not consider opening ACCT procedures on two occasions in early 2017: on 20 January when a prison GP recorded that Ms Burn was “very anxious and suicidal” about the reduction in her clonazepam medication, and on 9 February when the worker from the substance misuse team recorded that Ms Burn was stressed about her medication and spoke about not wanting to leave her children without a mother. We recommend:

The Head of Healthcare should remind all healthcare staff, including GPs, they have a responsibility to open ACCT procedures if they consider a prisoner is at risk of suicide or self-harm.
87. We are satisfied that Officer A appropriately opened ACCT procedures when Ms Burn was placed on the basic regime on 25 February and talked about hanging herself if her television was not returned.
88. The subsequent ACCT assessment carried out by SO B was commendably thorough and identified that Ms Burn had a significant number of risk factors: she was on the basic regime which meant she would spend more time locked in her room, a known risk factor for prisoners generally; she lacked family support, had suffered domestic abuse from her partner, was upset at not being allowed to contact her children and felt isolated; she had nowhere to live when she was released; she was upset about the reduction in her medication; she was complaining of significant pain and said she was not sleeping; and she said her mood was low and that she did not want to be alive and would hang herself if she had the opportunity. We consider that the SO appropriately assessed Ms Burn as a high risk to herself and that it was good practice to agree that she could have a television at night to help her sleep.
89. However, we are concerned that, although PSI 64/2011 says that healthcare staff should attend the first ACCT review, no healthcare staff were present at Ms Burn’s initial case review on 25 February, and there is no evidence they had been invited.

Healthcare input was particularly relevant for Ms Burn because her concern about her medication was one of her key risk factors. Without a healthcare input it was not possible to develop a comprehensive caremap.

90. The case manager recorded that they would invite substance misuse staff to the next review which was scheduled for 3 March. Given that Ms Burn was assessed as high risk, with multiple risk factors, we consider that the gap of six days between the initial review and the scheduled second review was much too long. We are concerned that those present at the review did not identify that there were few, if any, protective factors that would prevent Ms Burn carrying out her stated intention of killing herself. In our Learning Lessons Bulletin, Self-inflicted deaths among female prisoners, published in March 2017, and we found that staff may underestimate the risk of vulnerable women who present as very distressed and express thoughts of self-harm. We consider in this case that staff at the first case review did not take Ms Burn's risk to herself as seriously as they should have done.
91. On 28 February, Ms Burn was angry and distressed about her medication and complained of increased back pain. This had been identified as one of her key risk factors on 25 February. It was still unresolved, and she said her back pain was making her suicidal. She also said she had taken illicit prescription medication. The next scheduled case review was still three days away and we consider that there should have been a fresh case review to reassess Ms Burn's risk.
92. PSI 64/2011 says that the ACCT Plan must travel to and from any location the prisoner moves to, to ensure that the receiving member of staff is informed of the prisoner's risk status and is able to input to the ACCT Plan On-Going Record. We are therefore concerned that GP who saw Ms Burn on 2 March to review her medication said he did not know she was on an ACCT. This is particularly concerning as the medication issue was one of Ms Burn's key risk factors. We recommend:

The Governor and Head of Healthcare should ensure that the ACCT document accompanies prisoners when they move around the prison, including to healthcare appointments.

93. After seeing the GP, Ms Burn returned to the wing in an angry mood because she still did not consider that her medication issue had been resolved. Staff had to use 'minimal force' to return her to her room and she was clearly distressed when she was locked in. Officer C appropriately called for assistance because Ms Burn had hidden herself in her room. However, given the degree of Ms Burn's distress, we consider that this was another missed opportunity to hold an ACCT case review and consider whether Ms Burn's risk to herself had increased and whether the level of observations should be increased.
94. Instead, staff held an informal discussion and decided that Ms Burn would no longer be allowed to have a television overnight as she was not following the rules. We have identified in previous PPO publications the importance of prison staff considering the risks associated with withdrawing privileges when prisoners are being monitored on the ACCT process. We are concerned that the decision not to allow Ms Burn to have the television overnight was taken outside the ACCT procedures and without consideration of the impact it might have on Ms Burn's risk to herself.

95. As the overnight television had been explicitly agreed as a measure to reduce Ms Burn's risk, we consider that this was an error of judgement, particularly by the two most senior staff involved: a senior manager and CM A. Ms Burn was left in her room in a distressed state with two key risk factors unresolved: she did not consider her medication was effective and she had lost the overnight television she considered essential to enable her to sleep at night. These risk factors should have been at the forefront of staff's thinking, but instead they appear to have focussed on taking punitive action in response to Ms Burn's behaviour.
96. It is unfortunate that Nurse A arrived on A wing to conduct a mental health assessment, not knowing that the managers were discussing Ms Burn. Her input to a formal ACCT review would have been an asset.

The 'noose'

97. We are very concerned that, despite knowing that Ms Burn was on an ACCT and had been assessed as posing a high risk to herself, and was now alone in her room in a distressed state, Officers B and C did not attempt to remove the piece of fabric they saw hanging in Ms Burn's room, and that SO A did not take any action when the officers told him about the fabric and he saw Ms Burn pulling a piece of sheet.
98. We are concerned that none of the staff asked her about it, tried to remove it or asked her where it was when they noticed it had disappeared. Given the circumstances and Ms Burn's state of mind at the time, we consider that the presence of the fabric – which staff described at the time as a 'noose' and a 'ligature' - should certainly have prompted an ACCT review and consideration of whether Ms Burn should be subject to constant watch.
99. We make the following recommendations:

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

- **Mental health staff attend or contribute to all ACCT reviews for prisoners in their care and are fully involved in decisions about their level of risk.**
- **A member of healthcare staff should attend all first case reviews and subsequent reviews where relevant.**
- **Case reviews assess the risk of suicide or self-harm based on all available information and known risk factors and set a level of observations which reflects that risk.**
- **Staff review risk and consider whether to hold a case review whenever an event occurs which indicates an increase in risk.**
- **The Governor should consider initiating an investigation into the actions of SO A and Officers B and Officer C in relation to the piece of fabric they saw in Ms Burn's room on 2 March 2017, with a view to considering whether disciplinary action is appropriate.**

The Governor should share this report with Officer A, SO B, the senior manager and CM A and arrange for a senior manager to discuss it with them to ensure they are aware of the Ombudsman's findings.

Clinical care

100. The clinical reviewer concluded that, although some of Ms Burn's clinical care was of a very high standard, the lack of healthcare input into the ACCT case review meant that her care was not equivalent to what might have been expected in the community.

Primary care

101. The clinical reviewer noted that Ms Burn had good access to primary care nurses and had appropriate access to a GP when required. However, she did identify some concerns.
102. We share the clinical reviewer's concern that the nurse who carried out the primary health screen when Ms Burn arrived at Downview, incorrectly noted that she had no history of self-harm. This was contrary to the transfer information. In interview the nurse said that she only records what the prisoner tells her at an initial health screen and that she did not have time to check or read previous records, including the PER and any suicide/self-harm warning forms. This could have serious consequences and is not acceptable. We recommend:

The Governor and Head of Healthcare should ensure that nurses conducting reception health screenings always have access to the PER and have time to read it.

103. Although Ms Burn often denied any mental health concerns when asked directly, she did appear to be suffering from anxiety. The clinical reviewer thought that Ms Burn may have benefited from a holistic assessment of her mood by her GP team, although she noted that it was not certain that Ms Burn would have engaged with them.
104. The clinical reviewer noted that the GPs involved in Ms Burn's care wanted to review her prescription of clonazepam for epilepsy. They tried to engage with her but when she did not attend the arranged appointments, a GP decided to proceed as planned and began a slow reduction of clonazepam in line with British Formulary guidelines.
105. This was not unreasonable as there was no evidence that Ms Burn had been diagnosed with epilepsy and clonazepam is an addictive drug which is abused and traded illicitly in prisons. However, it appears that the reduction in her medication caused Ms Burn great distress and the clinical reviewer queried the value of attempting the reduction in Ms Burn's short time at HMP Downview

Substance misuse

106. The clinical reviewer concluded that the management of Ms Burn's substance misuse was in keeping with the recommended guidelines. She was placed on a stable dose of methadone, rather than a reducing dose, as she was due to be

released within 6 months of arriving at Downview. The clinical reviewer commented that the assessments, support and note keeping of two members of staff were exemplary, and that Ms Burn stated that she felt supported by a particular member.

Inquest

107. No inquest was held in relation to Ms Burn's death.

**Prisons &
Probation**

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