

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Anil Gill, a prisoner at HMP Woodhill, on 31 July 2022

A report by the Prisons and Probation Ombudsman

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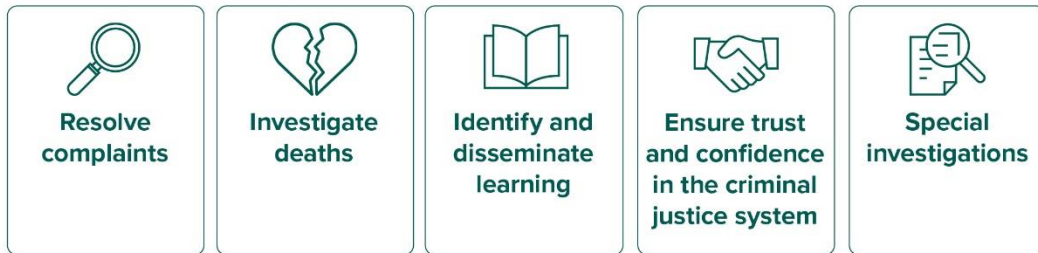
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OUR VISION

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



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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.

Mr Anil Gill died on 31 July 2022, after he was found hanging in his cell in HMP Woodhill. He was 48 years old. I offer my condolences to Mr Gill's family and friends.

Two weeks before he died, a family court judge stopped Mr Gill's contact with his youngest child at a hearing Mr Gill attended by video link with no staff present. I am concerned that there was no system in place at Woodhill for notifying staff of prisoners' attendance at family court hearings. This meant that staff supporting Mr Gill were unaware that his risk of suicide and self-harm might increase. The Governor has introduced a new process for notifying staff of family court hearings and organising follow up conversations to assess any risks. This will help encourage prisoners to share their concerns, although the risk that they choose not to remains. More broadly, I think HMPPS could do more to ensure that prison staff are alert to the specific risks of family court hearings.

On the morning that he was discovered, staff did not see Mr Gill during either the roll check or unlock process because his cell door observation panel was blocked. We found the same issue during an investigation into a previous self-inflicted death at Woodhill, six weeks prior. There is clearly learning for staff about the importance for safety and security of visually checking prisoners during these daily procedures. The Governor has already taken steps to prevent future occurrence and she will want to continue to monitor staff compliance and understanding.

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

November 2023

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Summary

Events

1. Mr Gill was remanded in custody in February 2021, charged with murdering his wife. Staff automatically started monitoring him under ACCT (the HMPPS' process to support those at risk of suicide and self-harm) because of the nature of the offence. He had no history of suicidal thoughts or self-harm, and the ACCT was closed after one month with no concerns having been raised. He reported symptoms of depression and was prescribed antidepressants.
2. In November, Mr Gill was convicted and sentenced to life imprisonment, with a minimum tariff of 22 years. Staff opened ACCT proceedings, but Mr Gill said he was not surprised by the tariff and had no thoughts of suicide or self-harm.
3. Mr Gill transferred to HMP Woodhill in December. He said he had no thoughts of suicide or self-harm and no other mental health issues. He understood the support that was available but did not need any at the time. Mr Gill settled into the regime and seemed to engage well with staff and other prisoners.
4. On 7 June 2022, the prison pharmacist noticed that Mr Gill had not collected his antidepressant medication for around three weeks. They added Mr Gill to the waiting list for a review of his medication.
5. On 18 July, Mr Gill attended a family court hearing via video link, at which the judge stopped contact between Mr Gill and his younger son. Mr Gill did not tell staff what had happened.
6. On the morning of 31 July, the officer who carried out the roll count on Mr Gill's wing found several observation panels blocked (meaning the officer could not see the prisoner inside the cell) and submitted the count without completing visual checks. When another officer later unlocked Mr Gill's cell, his observation panel was blocked, and the officer was unable to open the door. Half an hour later, the officer returned with a colleague, and they could not open the door. They called a supervising officer and removed the blockage from the observation panel. Mr Gill had a ligature around his neck. The officers went into the cell and, with medical and then ambulance staff, attempted to revive Mr Gill. At 10.04am Mr Gill was pronounced dead.

Findings

Assessment of risk

7. Staff opened ACCT procedures on two occasions during Mr Gill's time at Woodhill. They did so automatically, when he first arrived due to the nature of his offence, and when he was convicted and given a long sentence, because of the potential increase in suicide and self-harm risk. This was in line with guidance. During his time in the prison, Mr Gill did not disclose any feelings that he wanted to harm himself and he appeared to be forward-looking.

8. Mr Gill attended a family court hearing on 18 July, via video link. He was not supervised, and staff were unaware that a decision had been made to end contact with his younger son.

Mr Gill's healthcare

9. The clinical reviewer concluded that Mr Gill's healthcare was partially equivalent to that which he could have expected to receive in the community.
10. When staff noticed that Mr Gill was not collecting his medication, they did not conduct a medications review.
11. When Mr Gill was found unresponsive in his cell, staff attempted to revive him despite signs that he had died.

Roll checks

12. The officer who completed the roll check on 31 July, a short time before Mr Gill was found, did not visually check all of the prisoners on the wing.

Blocked observation panels

13. On the day that Mr Gill was found dead, officers completing unlock noticed his observation panel was blocked and did not challenge this to ensure visual checks could be completed. Staff told us this was commonplace, and we found the same issue during our investigation into a previous death at Woodhill, less than one month prior.

Cooperation with the PPO

14. We experienced significant delays in obtaining electronic evidence from Woodhill, which impacted on our ability to investigate Mr Gill's death.

Recommendations

- The Governor should ensure that staff are aware of prisoners attending family court hearings, and that risk assessments are completed following their appearances to identify any safeguarding concerns.
- The Director General of the Prison Service should consider amending PSI 64/2011 to include specific mention of family court hearings as a potential trigger for suicide and self-harm.
- The Head of Healthcare should ensure that prisoners who do not collect their medication are reviewed in line with policy, to ensure risks can be identified and appropriately managed.
- The Governor and Head of Healthcare should ensure that staff are aware of National Resuscitation Council Guidelines on the circumstances in which resuscitation is inappropriate.

- The Governor should ensure that staff understand the importance of visually observing a prisoner during a roll check for both safety and security reasons.
- The Governor should ensure that staff perform a visual welfare check on all prisoners during the unlock process.
- The Governor should evidence how the prison will continue to monitor the challenging of blocked observation panels, to ensure compliance.
- The Governor should ensure that all evidence, including electronic evidence, relevant to a death in custody is retained and made available to the PPO in line with PSI 58/2010.

The Investigation Process

15. The investigator issued notices to staff and prisoners at HMP Woodhill informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
16. The investigator visited Woodhill and obtained copies of relevant extracts from Mr Gill's prison and medical records. The prison was unable to provide recordings of Mr Gill's telephone calls. The prison also had difficulty in providing CCTV footage. He was able to view the CCTV footage at the prison and the prison provided him with a copy after some months. He also obtained information from South Central Ambulance Service and Thames Valley Police.
17. The investigator interviewed four members of staff at Woodhill in September 2022.
18. NHS England commissioned an independent clinical reviewer to review Mr Gill's clinical care at the prison.
19. We informed HM Coroner for Milton Keynes of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
20. The Ombudsman's family liaison officer contacted Mr Gill's sister, to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Gill's sister asked a question about telephone credit that we have answered in separate correspondence.
21. We shared our initial report with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies.
22. We sent a copy of our initial report to Mr Gill's sister. She did not notify us of any factual inaccuracies.

Background Information

HMP Woodhill

23. HMP Woodhill is a relatively modern prison in Milton Keynes. In addition to its role as a category B training prison, it holds several category A prisoners on remand and operates several specialist units, making it a complex and high-risk institution for just over 600 men. Central and North-West London NHS Foundation Trust provides health services at the prison.

HM Inspectorate of Prisons

24. The most recent inspection of HMP Woodhill was in June 2022. Inspectors reported that leaders and managers demonstrated a will and desire to improve outcomes for prisoners, but much of their effort was thwarted by staff shortages.

Independent Monitoring Board

25. 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 May 2021, the IMB reported high levels of violence, but that prisoners were largely treated humanely. There were staffing issues, but healthcare services operated well.

Previous deaths at HMP Woodhill

26. Mr Gill was the fourth prisoner to take his own life at Woodhill since May 2019. Since then, another death has occurred for which the cause is unknown. We identified issues with blocked observation panels in a previous investigation of a death that took place in June 2022 and made a related recommendation.

Assessment, Care in Custody, and Teamwork (ACCT)

27. 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.
28. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.
29. 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

30. Mr Gill was remanded to HMP Bullingdon on 2 February 2021, charged with the murder of his wife. When arrested, police found what they thought was a suicide note, but Mr Gill said it was just instructions to his family for when he was in prison.
31. On arrival at Bullingdon, Mr Gill was asked about suicide and self-harm and said he had no thoughts of harming himself. Staff automatically started monitoring Mr Gill under ACCT procedures, because of the nature and seriousness of his offence. Mr Gill moved to HMP Peterborough later in February and remained under ACCT management until 1 March. Staff recorded no concerns about his risk.
32. In May, Mr Gill transferred to HMP Wormwood Scrubs. He reported symptoms of depression and was prescribed antidepressant medication. In October, Mr Gill transferred to HMP Bedford to attend his trial. (Bedford was closer to the court Mr Gill was attending.)
33. On 15 November, Mr Gill appeared in court and was convicted of murder and sentenced to life imprisonment with a minimum tariff of 22 years. When he returned to Bedford, staff opened ACCT procedures because of the length of his sentence. Mr Gill said that he was not surprised by the length of his sentence and had no thoughts of harming himself. He said he had good support from his family, was making plans for his future, and hoped to have contact with his two sons. No concerns were raised, and ACCT procedures were closed on 21 November.

HMP Woodhill

34. Mr Gill transferred to HMP Woodhill on 23 December. In his initial health screening, he said he had no mental health issues and no thoughts of self-harm. In an interview with a member of staff from the Safer Custody Team (responsible for overseeing ACCT procedures), he said that while he had lost everything, he understood that he was not long into his sentence. He talked again about support from his family and his awareness of support systems in the prison. He said that he had no intention of harming himself and did not need any support at the time.
35. Mr Gill said the same at his prison induction interview and said that he was happy to be at Woodhill. He saw a nurse from the mental health team as part of the induction and said that he felt settled, was mentally and physically well and had no thoughts of harming himself. He told staff that he knew how to contact the doctor if he had any concerns. His prescription for antidepressant medication continued.
36. In April 2022, Mr Gill said that he wanted to convert to Islam. Woodhill staff, including the chaplaincy, supported him in doing so.
37. On 7 June, the prison pharmacist noticed that Mr Gill had not collected his antidepressant medication for three weeks. The pharmacist added Mr Gill to the non-compliance waiting list, to ensure that his prescription was reviewed, but we found no evidence that the review took place.

38. On 14 July, Mr Gill met with his Prison Offender Manager (POM). He said he was interested in transferring to the therapeutic community in HMP Grendon. The POM explained to Mr Gill that he was not yet eligible because he was too early in his sentence. They discussed sentence progression and other risk reduction interventions that were available at Woodhill.
39. On 18 July, Mr Gill attended a family court hearing through a video link from prison. He was escorted to the video link room but not supervised by staff during the hearing, as was standard practice for family court appearances at Woodhill. At the hearing, Mr Gill was told that he would not be allowed any contact with his younger son. He did not speak to staff about the decision that had been made and no one assessed his risk after the hearing.
40. In the days following the family court hearing, we found nothing of note in Mr Gill's prison or healthcare records. He applied to work in a different area of the prison and was told that his request would be considered. Reports from his then workplace were good and described Mr Gill as a positive and calming member of the group.

Events of 31 July

41. Shortly after 7.00am on the morning of 31 July, Officer A conducted a roll count (to confirm that the correct number of prisoners are in the prison) on A and B wings, which included Mr Gill's cell. The officer said that several prisoners had covered the observation panels in their cell doors, which was not unusual (but is not allowed at Woodhill). He said that when he was unable to see into a cell, he would rattle either the observation panel or the door handle until he heard a noise from inside the cell. The cells at Woodhill are all single occupancy, so he said that if he heard a noise, he would know the prisoner was in the cell. In interview, he told us that he was confident that he had a response from each cell that morning, however he could not recall whether Mr Gill's observation panel was blocked or if he had seen him.
42. Officer B was unlocking cells and at 9.04am, he unlocked Mr Gill's. The observation panel was still covered. He was unable to open the door more than a small distance because something was pushing it back. A prisoner told him that Mr Gill usually pushed against the door when he needed privacy while using the toilet. He locked the cell and told Officer C what had happened. Officer C said that Mr Gill would sometimes push the door closed when using the toilet. We could not interview Officer B because he had left the Prison Service by the time of our investigation.
43. Both officers were responsible for conducting cell checks later that morning. They started on Mr Gill's spur because they had not seen him at the roll check or unlock earlier in the day. CCTV footage showed that they reached his cell at 9.39am. They were still unable to open the door due to the resistance behind it and the observation panel was still covered. One of Mr Gill's feet could be seen at the bottom of the door, but the officers did not know why he was blocking it. The officers called a Supervising Officer (SO), who called to Mr Gill through the door, but did not get a response. He asked Officer C to get an anti-barricade key (which would allow staff to open the door outwards) and asked Officer B to reach in and

remove the obstruction on the observation panel. When the observation panel was cleared, the officers were able to see Mr Gill on the floor with a ligature made from a bed sheet around his neck, tied to the end of his bed. His legs were stretched out in front of him, blocking the door. The SO used his radio to call a code blue emergency (meaning a prisoner is unconscious or having trouble breathing), which prompted the control room to call an ambulance at approximately 9.44am.

44. Officer C returned to the cell soon after with the anti-barricade key and the officers opened the door. They removed the ligature from Mr Gill's neck and laid him on the floor. He was unconscious and not breathing. Medical staff had responded to the emergency call, and nurses and prison officers attempted to revive Mr Gill. They performed cardiopulmonary resuscitation (CPR) and applied a defibrillator (a machine that in some instances can restart the heart), which advised them to continue with CPR. They did so until ambulance paramedics arrived and took over. At 10.04am, it was agreed that Mr Gill had died.
45. Staff found a note in Mr Gill's cell, which was provided to police. The note was addressed to Mr Gill's family.
46. Staff also found a vape cap containing a small bag of herbal substance in Mr Gill's cell. Intelligence reports after Mr Gill died suggested that a prisoner had given him some psychoactive substances the night before he died. We found no evidence to verify this allegation.

Contact with Mr Gill's family

47. Two Custodial Managers were appointed family liaison officers. They identified Mr Gill's sister as his next of kin and went to her address to inform her of Mr Gill's death. In line with Prison Service guidance, Woodhill contributed to the cost of Mr Gill's funeral.

Support for prisoners and staff

48. After Mr Gill's death, one of the prison's senior managers 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.
49. The prison posted notices informing other prisoners of Mr Gill'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 by Mr Gill's death.

Post-mortem report

50. The post-mortem examination found that Mr Gill died as a result of hanging. Toxicology tests showed no synthetic cannabinoids (psychoactive substances commonly used in prisons), and no antidepressant medications in Mr Gill's system. There was a low level of cannabis in his system.

Findings

Assessment of risk

51. Prison Service Instruction (PSI) 64/2011 *Managing Prisoner Safety in Custody* contains national requirements on the assessment and management of suicide and self-harm risks in prisons. The instruction lists risk factors and potential triggers that staff should be alert to and act appropriately to address. Any prisoner identified as at risk of suicide and self-harm must be managed under ACCT procedures.
52. Staff monitored Mr Gill under ACCT procedures on two occasions, following significant events which are widely recognised to increase the risk of harm. Once when he arrived in prison charged with murdering his wife, and later when he was given a long prison sentence. Mr Gill said that he felt low at times but had no thoughts of suicide or self-harm. He appeared to be forward-looking and considering his sentence progression. Staff saw no obvious signs that he was in crisis.
53. On 18 July, Mr Gill received upsetting news when he attended a family court hearing. As was standard practice for family court appearances at Woodhill, no staff were present with him during the hearing. Mr Gill did not share what had happened with staff, so they were unaware of the potential increase in risk.
54. We cannot say what the impact of the decision was on Mr Gill and found no evidence that staff had missed any obvious signs of crisis, but he took his life less than two weeks after the hearing and court appearances are a recognised potential risk factor for suicide and self-harm. At the time of our investigation, there was no process in place at Woodhill to assess the impact on individuals, particularly those who appeared via video link and so were not processed through the reception area on their return from an in-person appearance. We have previously raised concerns about the lack of formal monitoring in prisons after video link court appearances. In interview, the Safer Prisons Team manager told us that a new process had been introduced to address the learning. Woodhill now issue a daily email notification to managers, detailing all court appearances. The expectation is that managers notify relevant wing staff, who can follow up with individuals and provide support if required. We recognise that staff remain reliant on prisoners disclosing their concerns, which they may not always feel able to do, but it is important that there is an opportunity for this.
55. PSI 64/2011 lists potential risks and triggers for suicide and self-harm, including court appearances, “especially start of trial and sentencing”. The policy does not specifically mention family court hearings and we consider this a missed opportunity to remind staff of the potentially traumatic outcomes of family court hearings. We make the following recommendations:

The Governor should ensure that staff are aware of prisoners attending family court hearings, and that risk assessments are completed following their appearances to identify any safeguarding concerns.

The Director General of the Prison Service should consider amending PSI 64/2011 to include specific mention of family court hearings as a potential trigger for suicide and self-harm.

Mr Gill's healthcare

56. The clinical reviewer concluded that the care Mr Gill received at Woodhill was partially equivalent to that which he could have expected to receive in the community.
57. Healthcare staff did not follow national guidelines on medications management when Mr Gill did not collect his antidepressants for three weeks. The prison pharmacist noted the lack of compliance and added Mr Gill to the list for a review, but we found no evidence that this took place. We make the following recommendation:

The Head of Healthcare should ensure that prisoners who do not collect their medication are reviewed in line with policy, to ensure risks can be identified and appropriately managed.

58. The Quality Standards for Clinical Practice and Training in Cardiopulmonary Resuscitation, published by the Resuscitation Council, were updated in 2020. The Resuscitation Council guidance says, "There will be some people for whom attempting CPR is clearly inappropriate; for example, there will be cases where healthcare professionals discover patients with features of irreversible death, for example, rigor mortis".
59. The clinical reviewer noted that CPR was commenced despite clear indications that Mr Gill had died. We recognise the traumatic circumstances in which staff found Mr Gill and that their actions were to preserve life, however it is important that staff follow national guidelines to protect the deceased from unnecessary physical trauma and themselves from further distress. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff are aware of National Resuscitation Council Guidelines on the circumstances in which resuscitation is inappropriate.

Roll checks

60. PSI 75/2011 *Residential Services* says that prisoners should be accounted for at daily roll checks. Woodhill reflect this in their local Governor's Order '*Roll Check Requirements*' dated 18 February 2022. The Order states that "a roll check involves each cell door being checked and doing a visual check of the person in the cell ... A verbal response only without visual sight is not sufficient". Officer A could not recall whether he saw Mr Gill when he conducted the roll check on the morning of 31 July. He told us that several cells that morning had blocked observation panels and he confirmed the roll check without actually seeing all of the prisoners. In interview he said that this was not unusual. We make the following recommendation:

The Governor should ensure that staff understand the importance of visually observing a prisoner during a roll check for both safety and security reasons.

Blocked observation panels

61. In February 2018, HMPPS issued a Safety Bulletin on Observation Panels. This said that if a prisoner does not comply with instructions to remove a blockage, staff must take immediate action to remove the obstruction and check the prisoner's welfare. It is quite possible that Mr Gill's observation panel was blocked when Officer A went to his door, and it was blocked when Officer B later unlocked the door. The obstruction was only removed when a manager arrived sometime later.
62. During our investigation into the self-inflicted death of another prisoner, who died at Woodhill six weeks before Mr Gill, we identified that it was common practice for staff not to challenge prisoners about blocked observation panels.
63. On 26 August 2022, the Governing Governor at Woodhill issued a staff information notice reminding staff that they must take immediate action when they find a blocked observation panel and not leave the cell until the obstruction has been removed. The same day, she issued a notice to prisoners advising them that obstructing observation panels would result in punitive action. While we are concerned to find the same issues across two investigations, we note the action that has been taken to address the learning and recognise that cultural change takes time. We make the following recommendation:

The Governor should evidence how the prison will continue to monitor the challenging of blocked observation panels, to ensure compliance.

Unlock procedures

64. The Prison Officer Entry Level Training (POELT) manual says that before unlocking a cell, staff should physically check that the prisoner is present. It says that staff must ensure that they receive a positive response from the prisoner by knocking on the door and waiting for a sign of acknowledgment. The manual says that if staff do not get a response, they may need to open the cell to check that the prisoner has not escaped, is not ill or dead.
65. Prison Service Instruction (PSI) 75/2011, *Residential Services* says that:

“Reports from the Prisons and Probation Ombudsman on deaths in custody have identified cases in which a prisoner has died overnight ... but staff unlocking them have not noticed that the prisoner had died. This is not acceptable... “

“...there need to be clearly understood systems in place for staff to assure themselves of the wellbeing of prisoners during or shortly after unlock .. Where prisoners are not necessarily expected to leave their cell, staff will need to check on their wellbeing, for example, by obtaining a response during the unlock process.”
66. When Officer B was unable to open Mr Gill's door at unlock on 31 July, a prisoner told him that Mr Gill often held the door shut with his foot while using the toilet. Officer C confirmed this, and the officers agreed that they would go back to check

on Mr Gill when they began cell checks later in the morning. They returned to Mr Gill's cell over half an hour later at 9.39am.

67. We are concerned that unlocking cells without visual checks of the prisoners inside has become accepted practice among some staff at Woodhill. We are unable to say how this may have affected Mr Gill, as we cannot be certain when he died. However, this could make a crucial difference to future outcomes. We make the following recommendation:

The Governor should ensure that staff perform a visual welfare check on all prisoners during the unlock process.

Substance misuse

68. An intelligence report was submitted following Mr Gill's death, alleging that he had been given a psychoactive substance (PS) the night before he died. We informed HM Coroner for Milton Keynes, who confirmed that there were no traces of PS in Mr Gill's system, post-mortem. Tests showed that Mr Gill had cannabis in his system, and a small amount of herbal substance was found in his cell. We found no other evidence that Mr Gill used substances during his time in prison.

Cooperation with the PPO

69. PSI 58/2010 *Prisons and Probation Ombudsman* requires prisons to provide evidence to the Ombudsman's office for the purpose of our investigations. On 8 August we asked for recordings of Mr Gill's telephone calls and the radio traffic relating to the emergency response to be preserved and provided to us. This was not received until December. We make the following recommendation:

The Governor should ensure that all evidence, including electronic evidence, relevant to a death in custody is retained and made available to the PPO as soon as possible, in line with PSI 58/2010.

Inquest

70. The inquest, which concluded on 2 June 2023, recorded a conclusion of suicide.

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