

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Bradley Charnley, a prisoner at HMP Risley, on 13 August 2020

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.

Mr Bradley Charnley was found hanged in his cell at HMP Risley on 13 August 2020. He was 23 years old. I offer my condolences to Mr Charnley's family and friends.

Mr Charnley had a history of mental health problems, substance misuse and self-harm. However, although Mr Charnley had risk factors for suicide and self-harm, there was little to indicate to prison staff that he was at imminent risk of suicide.

I am, however, concerned that Mr Charnley did not have a planned mental health assessment in the weeks before he died, and there is no evidence that his mental health was monitored in that time. This was a missed opportunity to review Mr Charnley's mental health and wellbeing fully before he died. I have also recommended a more collaborative approach between the substance misuse team and the mental health team.

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

Sue McAllister CB
Prisons and Probation Ombudsman

May 2021

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Summary

Events

1. Mr Bradley Charnley had a history of mental health problems, substance misuse and self-harm, and had been in prison several times since the age of 16.
2. He was transferred to HMP Risley on 28 June 2019. He was referred to the substance misuse and mental health teams when he arrived.
3. On 16 June 2020, following a deterioration in his mental health, a nurse started a full assessment of Mr Charnley's mental health, but was unable to complete a comprehensive assessment due to time restraints imposed as a result of the COVID-19 pandemic. Although she scheduled a follow-up appointment for four to six weeks' time, it never took place and he was not monitored or reviewed in the meantime.
4. On 13 August at around 5.08am, while conducting his morning roll check, the night patrol officer found Mr Charnley hanging in his cell and immediately radioed a medical emergency 'code blue', indicating a life-threatening situation. The night patrol officer waited for assistance from his manager who arrived within seconds, closely followed by two officers and a nurse. They entered the cell and found signs of rigor mortis, so did not attempt to resuscitate Mr Charnley. At 5.34am, paramedics confirmed Mr Charnley had died.

Findings

Management of risk of suicide and self-harm

5. We consider that Mr Charnley gave prison staff no reason to consider that he was at imminent risk of self-harm and suicide in the days and weeks prior to his death. We conclude that his death was not foreseeable.

Mental health assessment and follow-up

6. However, we agree with the clinical reviewer that Mr Charnley's mental health was not fully assessed following a referral in May 2020. Mental health staff did not monitor or assess him again over the next four to six weeks, as planned. We consider that the failure to follow-up the interrupted mental health assessment was a missed opportunity to review Mr Charnley and put in place appropriate support before he died.
7. For this reason, the clinical reviewer concluded that the mental health care Mr Charnley received at Risley was not equivalent to that which he could have expected to receive in the community.
8. We were told that mental health services were restricted at the time at Risley because of the COVID-19 pandemic.

Substance misuse

9. Despite Mr Charnley's long history of substance misuse, post-mortem toxicology tests found no traces of drugs or alcohol in his system when he died.

10. The clinical reviewer found that Mr Charnley's mental health and substance misuse issues were significantly interlinked. We share her concern that although Mr Charnley clearly had both mental health and substance misuse needs, there was little joined up working from the two respective teams. We have recommended a more collaborative approach between the two teams.

Emergency response

11. The control room officer waited five to six minutes before calling an ambulance after receiving the code blue call. As a result, he failed to meet the requirements set out in Prison Service Instruction (PSI) 03/2013, which state that an ambulance should be called immediately after an emergency code. Although it would not have saved Mr Charnley's life, we consider that such a delay could be crucial in future emergencies.
12. We have no other concerns regarding the emergency response, which was prompt, professional and appropriate.

Key working

13. We commend Mr Charnley's key worker who saw Mr Charnley regularly and developed a meaningful relationship with him.

Recommendations

- The Head of Healthcare should:
 - work with the Mental Health Lead to ensure there is a robust system for timely mental health referrals and assessments; and
 - ensure that mental health appointments are appropriately recorded on SystemOne.
- The Head of Healthcare and Substance Misuse Team Manager should ensure that they work collaboratively to improve joint working and joint care planning for patients with both substance misuse and mental health issues.
- The Governor should ensure that all staff are made aware of and understand PSI 03/2013, as well as local instructions, and their responsibilities during medical emergencies, including:
 - immediately calling an ambulance when a medical emergency code is called; and
 - promptly providing information about a prisoner's condition to the control room so that they have this information when requesting an ambulance.
- The Governor should share this report with the keyworker, so he is aware of the Ombudsman's findings.

The Investigation Process

14. The investigator issued notices to staff and prisoners at HMP Risley informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
15. The investigator obtained copies of relevant extracts from Mr Charnley's prison and medical records.
16. The investigator interviewed nine members of staff at Risley. The interviews were completed by video link and telephone due to the restrictions imposed as a result of the COVID-19 pandemic.
17. NHS England commissioned a clinical reviewer to review Mr Charnley's clinical care at the prison. The majority of the interviews were conducted jointly by the clinical reviewer and the investigator.
18. We informed HM Coroner for Cheshire of the investigation and have sent the coroner a copy of this report.
19. We contacted Mr Charnley's family to explain the investigation and to ask if they had any issues that they wanted the investigation to consider. We have not received any questions from the family, and they have not requested a copy of this report.
20. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS identified some factual inaccuracies, which we have addressed in this report.
21. The initial report was also shared with NHS England. NHS England identified one factual inaccuracy, which we have addressed in this report.

Background Information

HMP Risley

22. HMP Risley is a medium security training prison which holds over 1,000 convicted men. Manchester Mental Health NHS Foundation Trust provides healthcare services in the prison. Greater Manchester West Mental Health Foundation Trust provide mental health services. Substance misuse services are provided by Change, Grow, Live (CGL). There is 24-hour healthcare cover.

HM Inspectorate of Prisons

23. The most recent full inspection of HMP Risley was in June 2016. Inspectors reported that support for prisoners at risk of suicide and self-harm was adequate, but the quality of ACCT documentation varied. Inspectors found the mental health team was enthusiastic and well-led. A weekly meeting identified men needing immediate attention and those needing a routine mental health assessment were usually seen within two weeks.
24. HMIP also carried out a scrutiny visit to Risley in November 2020 on the conditions and treatment of prisoners during the COVID-19 pandemic. They found that the amount of violence and self-harm had reduced at the start of the restrictions. There had been a subsequent rise in the number of incidents, but this remained below pre-pandemic levels. This was in the context of improved prison safety and reducing trends in both violence and self-harm in the year up to the pandemic. Safety meetings had continued throughout the pandemic and managerial oversight of this area was good. Inspectors found evidence of a good level of support for prisoners at risk of suicide or self-harm, supported by the ACCT case management process. They saw staff engaging well with prisoners. Most prisoners (79%) said that staff treated them with respect. Key work had been well embedded in the prison before the pandemic, and weekly checks on the well-being of more vulnerable prisoners and those near to release had continued during the COVID-19 period.

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 March 2018, the IMB reported that 53% of prisoners on A-E Wings did not feel safe. (Mr Charnley lived on A Wing.) The number of prisoners on ACCT suicide monitoring procedures at Risley had decreased.

Previous deaths at HMP [Prison]

26. Mr Charnley was the fourth prisoner to take his own life at Risley since August 2018. There were no notable similarities in the first two cases to the death of Mr Charnley. The third case is still being investigated by the Ombudsman.

Assessment, Care in Custody and Teamwork

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. 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.
28. 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. 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

29. Mr Bradley Charnley first served a custodial sentence in 2013, when he was 16 years old. He served several sentences over the next seven years. He had a long history of mental health problems, substance misuse and self-harm, and a complex custodial history. Mr Charnley's medical records contain frequent references to his substance misuse (psychoactive substances (PS), cannabis, amphetamine, cocaine and ecstasy). He was assessed as at risk of suicide or self-harm several times and monitored under HMPPS suicide prevention measures, known as ACCT. He reported auditory and visual hallucinations to the mental health team, which he said lessened when he reduced his PS use.
30. On 20 February 2018, Mr Charnley was released from prison on licence. After committing further offences, he was recalled to prison and taken to HMP Preston on 15 March. During the course of his offences, Mr Charnley self-harmed by stabbing himself in the neck with a knife. When he arrived at Preston, he was assessed as at risk of suicide or self-harm and was subject to ACCT monitoring.
31. On 26 October 2018, Mr Charnley was sentenced to 44 months' imprisonment for affray and threats to kill.
32. Mr Charnley was transferred to HMP Lancaster Farms on 19 November 2018. Mr Charnley failed to attend several mental health appointments during his time at Lancaster Farms and his behaviour became increasingly chaotic. Staff segregated him following his suspected involvement in a serious assault on a prisoner on 21 June 2019. (Mr Charnley was later interviewed by police as part of a related manslaughter investigation, but no charges were brought against him.) From 24 June, staff monitored Mr Charnley under ACCT procedures (starting with a short period of constant supervision) after he tried to stab himself with a television aerial, repeatedly headbutted a window and his cell wall, and threw himself off his bed.

HMP Risley

33. Although he was still subject to ACCT monitoring, Mr Charnley was transferred to HMP Risley on 28 June 2019 and located on D Wing. The reception nurse referred him to both the substance misuse and mental health teams for assessment.
34. Staff at Risley assessed that Mr Charnley was no longer at risk of suicide or self-harm and closed the ACCT on 1 July. They recorded that Mr Charnley seemed better and his behaviour was good, although they incorrectly noted that he had no history of self-harm.
35. On 3 July, the mental health team discussed Mr Charnley's referral. In the light of the ACCT review, they decided that there was no evidence that Mr Charnley had any mental health issues and discharged him from their caseload. They recorded that he would still get support from the substance misuse team (CGL).
36. On 10 July, Mr Charnley told a substance misuse team worker that he did not think he needed support because he was 'in a good place'.

37. Mr Charnley was subject to five Challenge, Support and Intervention Plans (CSIPs) while at Risley. (CSIP is a multi-disciplinary approach which focuses on those who pose a raised risk of being violent and works to change their behaviour. It is centred on the needs of the individual, providing them with support to improve and manage their behaviour.) Mr Charnley's keyworker said in interview that he thought it was possible that Mr Charnley was involved in illicit activity on D Wing and recalled that he was often involved in fights.

2020

38. On 6 May 2020, Mr Charnley told an officer that he was struggling with his mental health and wanted to engage with the mental health team. The officer submitted a paper referral for Mr Charnley the same day, but the mental health team did not note it on SystmOne until 18 May. Staff discussed Mr Charnley's referral at the next mental health team meeting on 20 May and scheduled a mental health triage assessment for 5 June.
39. On 2 June, a nurse examined Mr Charnley after he was found under the influence of PS. The nurse reported that Mr Charnley was alert and responsive, was of good colour and had no apparent injuries.
40. On 5 June, a mental health nurse carried out a mental health triage assessment, as planned. Mr Charnley described feeling "all over the place" and appeared uncomfortable and distressed. He said that his mental health had deteriorated after abstaining from illicit substances for two months. He reported that he had self-medicated and used illicitly obtained quetiapine (an anti-psychotic medication which he had been prescribed in the past). He described intrusive and racing thoughts, which were "too disgusting" to discuss, and said he had been exercising to help manage his mental state. After discussion at the next mental health team meeting, the nurse added Mr Charnley to her caseload and referred him for a full mental health assessment.
41. The same day, a substance misuse worker visited Mr Charnley and offered him advice following his use of PS three days earlier. Mr Charnley told her that he did not require support as he was engaging with the mental health team.
42. On 16 June, the mental health nurse saw Mr Charnley for a full mental health assessment but was unable to complete a comprehensive assessment due to time restraints imposed as a result of the COVID-19 pandemic. Mr Charnley again described having "disgusting" and intrusive thoughts, which he would swear at and try to bat away with his hand. Mr Charnley pulled unusual facial expressions during the assessment and appeared preoccupied. He said that he had been abstaining from drugs but had slipped up as he started using PS again to relieve his symptoms. He felt he would benefit from being treated with quetiapine. She told him that this could be considered if he stopped his illicit drug use.
43. The mental health nurse recorded that she did not feel that Mr Charnley was at risk of suicide or self-harm as he expressed thoughts about his future and was making plans for when he was released from prison. In interview, she said Mr Charnley seemed quite bright and engaged during the assessment and that she "didn't have any inkling at all that he had any intention on taking his life". She felt that a further period of monitoring (which she described in interview as "watch and wait") would

help gain a better understanding of the relationship between Mr Charnley's PS misuse and the symptoms he experienced.

44. The mental health nurse scheduled a follow-up assessment in her personal diary for four to six weeks' time. She made no corresponding entry in Mr Charnley's medical record. She told the investigator that she did not have time to carry out the follow-up assessment as planned due to the COVID-19 pandemic. She said that only urgent mental health cases (defined as prisoners who were acutely unwell and may need to be transferred to a secure hospital under the Mental Health Act) were being referred to the psychiatrist due to limited resources during the pandemic. She assessed that Mr Charnley's mental health needs were not urgent.
45. The keyworker met Mr Charnley after his mental health assessment on 16 June. He noted that Mr Charnley's mental health had deteriorated over the last few months. On 9 July, he noted that Mr Charnley's mental health had been affected by the prison lockdown in response to the COVID-19 pandemic, but that he was in good spirits and said he was seeing the mental health team who were helping him.
46. Following an assault on another prisoner on 13 July, staff moved Mr Charnley from D Wing to A Wing and managed him under a CSIP for the final time. The CSIP was closed three days later and no further action was taken. Mr Charnley said he was happy to have a fresh start on a new wing. The keyworker recorded that he had heard that Mr Charnley had been paid to assault the other prisoner.
47. On 11 August, the keyworker met Mr Charnley for the last time before he died. He noted, "Bradley still chilling on A Wing and enjoying his new environment. He has already made new friends and contacts on his new wing and is keeping out of trouble". He said in interview that Mr Charnley seemed "exactly the same as he always was" during their final meeting. He said Mr Charnley was always laughing and joking whenever they met. He described Mr Charnley as a "happy character", and said he had no suspicions in the days and weeks leading up to his death that he would self-harm.

12 August

48. At 4.18pm on Wednesday 12 August, Mr Charnley left his single cell and walked to the servery to collect his evening meal. Mr Charnley returned to his cell at around 4.20pm and an officer secured the door.
49. At 5.02pm, an officer checked Mr Charnley through his cell observation panel during his early evening roll check. He raised no concerns. An Operational Support Grade Officer (OSG) checked Mr Charnley in the same way at 9.08pm for the evening roll check. He raised no concerns.

13 August

50. At 5.08am on Thursday 13 August, during a morning roll check, the OSG saw Mr Charnley hanging in his cell. He immediately radioed a medical emergency 'code blue', indicating a life-threatening situation. The Custodial Manager (CM) arrived within seconds, closely followed by two officers and a nurse. According to the Ambulance Service's call record, the control room officer called an ambulance at 5.13am.
51. When the officers went into the cell, they found Mr Charnley hanging from the top of his toilet privacy screen by a ligature made from a piece of curtain. An officer said in his statement that he believed Mr Charnley's feet were either not touching the floor or only touching very slightly, and that the screen and ligature were taking his weight.
52. An officer cut the ligature and, with assistance from a colleague, laid Mr Charnley's body on the cell floor. He noticed a piece of broken razor blade on a unit in the cell. (This appears to have been used to cut the curtain to make the ligature.)
53. The nurse noted signs of rigor mortis, meaning Mr Charnley had been dead for some time, so staff did not attempt cardio-pulmonary resuscitation (CPR). At 5.34am, paramedics confirmed that Mr Charnley had died.
54. After Mr Charnley's death, the prisoner in the cell next door to Mr Charnley told an officer that Mr Charnley might have been in debt to other prisoners on the wing, as he had asked to borrow £5 to "pay a debt off". Another prisoner also mentioned that Mr Charnley owed £20 to a prisoner on the wing.

Contact with Mr Charnley's family

55. Mr Charnley had nominated his mother as his next of kin. The Governing Governor could not reach her on the telephone that morning. She called Mr Charnley's father at 7.15am on 13 August and broke the news of Mr Charnley's death to him. Risley maintained contact with Mr Charnley's family and, in line with national instructions, contributed to the costs of the funeral.

Support for prisoners and staff

56. The duty governor held one to one debriefs with prison staff involved in the emergency response. All staff and prisoners were offered the support of the prison's care team.
57. The prison posted notices informing other prisoners of Mr Charnley'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 Charnley's death.

Post-mortem report

58. A post-mortem examination identified Mr Charnley's cause of death as hanging. Post-mortem toxicology tests found no traces of drugs or alcohol. However, the toxicologist commented that because of the variable nature of PS, the possibility that Mr Charnley used PS prior to his death cannot be entirely excluded.

Findings

Management of risk of suicide and self-harm

59. Prison Service Instruction (PSI) 64/2011, which governs ACCT suicide and self-harm prevention procedures, 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 at risk of suicide or self-harm must be managed under ACCT procedures.
60. We have considered whether staff at Risley should have recognised Mr Charnley was at risk in the weeks and months leading up to his death and begun ACCT procedures to support him.
61. Mr Charnley had some risk factors. As set out in this report, he had a history of mental health issues and self-harm and used illicit substances. His keyworker said he had been affected by the restricted regime caused by COVID-19 and was concerned that Mr Charnley's mental health was deteriorating (although he was reassured by Mr Charnley that he was receiving help from the mental health team).
62. Despite Mr Charnley's troubled history, he had not self-harmed since June 2019, prior to his transfer to Risley, and in the months leading up to his death he did not present or express any thoughts of suicide or self-harm during his contact with prison staff. At interview, officers told us of their shock and surprise at Mr Charnley's death. Both the officer who conducted Mr Charnley's final CSIP and his keyworker, with whom he had a close relationship, knew Mr Charnley well and thought he seemed his normal self. We cannot say that staff could have identified him as at imminent risk of suicide or self-harm before he died. We consider that Mr Charnley's death was not foreseeable.

Mental Health Assessment and Follow-Up

63. The clinical reviewer noted that Mr Charnley's substance misuse impacted significantly on his mental health and resulted in an increase in psychotic symptoms, including auditory and visual hallucinations, which in turn contributed to his risk of suicide or self-harm.
64. The clinical reviewer was concerned about what she described as "an unacceptable time lapse" between Mr Charnley's mental health referral made on 6 May and its consideration at the mental health team meeting on 20 May.
65. Mr Charnley's eventual mental health assessment on 16 June 2020 was interrupted and the nurse did not review him in four to six weeks as she had planned.
66. The mental health nurse said that Mr Charnley was making plans for the future and did not appear to be at risk when she saw him on 16 June. We note that making plans for the future is not a reliable guide to a prisoner's risk of suicide. As we have said repeatedly, it is important that staff take into account the prisoner's risk factors and do not rely solely on what he says or how he presents. In this case, in order to assess Mr Charnley's risk to himself, the nurse should have taken into account his previous history of self-harm, his admitted use of PS, and his psychotic symptoms, and should have considered whether these symptoms might be exacerbated by his

PS use and/or by the fact that he was spending long periods locked in his cell because of the COVID restrictions.

67. It is not possible to say whether the failure to follow-up the interrupted mental health assessment impacted on Mr Charnley's death, but we are concerned that it was a missed opportunity to review Mr Charnley and put measures in place to support him before he died.
68. The mental health nurse told the investigator that she used a personal diary to record when Mr Charnley's follow-up appointment would be and did not record it on SystmOne (the electronic medical record). We agree with the clinical reviewer that this is not good clinical practice.
69. The clinical reviewer concluded that Mr Charnley's mental health care at Risley was not equivalent to that which would have been received in the wider community. Although we appreciate the difficulty of maintaining services during the COVID-19 pandemic, we make the following recommendations:

The Head of Healthcare should:

- **work with the Mental Health Lead to ensure there is a robust system for timely mental health referrals and assessments; and**
- **ensure that appointments are appropriately recorded on SystmOne.**

Substance misuse

70. Mr Charnley had an extensive history of substance misuse and had admitted using PS in June 2020. Despite this, toxicology tests found no traces of drugs or alcohol in his system when he died.
71. The clinical reviewer concluded that Mr Charnley's mental health and substance misuse issues appear to have been significantly interlinked. She noted that when Mr Charnley was at HMP Haverigg, there was a very consistent and collaborative approach to managing this. However, this approach was not continued when Mr Charnley was transferred to HMP Lancaster Farms and later to Risley.
72. The clinical reviewer concluded that although Mr Charnley clearly had both mental health and substance misuse needs, there was little joined up working from the two respective teams at Risley. We agree with the clinical reviewer that a more collaborative approach needs to be adopted going forward. We make the following recommendation:

The Head of Healthcare and Substance Misuse Team Manager should ensure that they work collaboratively to improve joint working and joint care planning for patients with both substance misuse and mental health issues.

Emergency response

73. Prison Service Instruction (PSI) 03/2013 requires Governors to have a medical emergency response code protocol, which instructs staff how to communicate the nature of a medical emergency using agreed emergency codes and ensure that the

control room calls an ambulance immediately as soon as an emergency code is called.

74. The OSG radioed a code blue medical emergency promptly when he found Mr Charnley hanging.
75. The control room officer recorded in his handwritten log that he received the code blue call from the OSG at 5.07am (the CCTV footage shows it as being 5.08am exactly). Although the control room officer recorded that he called an ambulance at 5.11am, the Ambulance Service call record (which is exact) says it was 5.13am. It would not have saved Mr Charnley's life if the ambulance had been called earlier as he had been dead some time when he was found. However, we are concerned that there appears to have been a five to six-minute delay from receiving the code blue to calling an ambulance. This could make a critical difference in other medical emergencies.
76. At interview, the control room officer said he waited to obtain the prisoner's name, approximate age, exact location and other information before calling an ambulance, and described this approach as "good practice". We consider that the prison should have a local emergency protocol which requires staff to quickly relay information required for the ambulance, including whether the patient is conscious and breathing.
77. We recommend:
The Governor should ensure that all staff are made aware of and understand PSI 03/2013, as well as local instructions, and their responsibilities during medical emergencies, including:
 - **immediately calling an ambulance when a medical emergency code is called; and**
 - **promptly providing information about a prisoner's condition to the control room so that they have this information when requesting an ambulance.**
78. In other respects, the emergency response by the staff who found Mr Charnley and responded to the code blue was prompt, professional and appropriate. We share the clinical reviewer's view that staff in the emergency response acted appropriately and with professionalism in what must have been challenging circumstances.

Key working

79. The key worker scheme is a key part of HMPPS's response to self-inflicted deaths, self-harm and violence in prisons. It is intended to improve safety by building better relationships between staff and prisoners and helping prisoners settle into life in prison. All prisoners in the male closed estate must be allocated a key worker whose responsibility is to engage, motivate and support them through the custodial period. Governors in the male closed estate must ensure that time is made available for an average of 45 minutes per prisoner per week for delivery of the key worker role, which includes individual time with each prisoner.
80. The keyworker for Mr Charnley met him very regularly and made detailed notes of their conversations in Mr Charnley's electronic record. It is clear that the officer had

developed a good working relationship with Mr Charnley, and we commend him for that. We recommend:

The Governor should share this report with the keyworker, so he is aware of the Ombudsman's findings.

Inquest

81. The inquest into Mr Charnley's death concluded on 19 May 2023. Mr Charnley's death was caused by hanging.

**Prisons &
Probation**

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