

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Stephen Browning a prisoner at HMP Leeds on 3 August 2018**

**A report by the Prisons and Probation Ombudsman**

## Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

## Our Values

We are:

**Impartial:** *we do not take sides*

**Respectful:** *we are considerate and courteous*

**Inclusive:** *we value diversity*

**Dedicated:** *we are determined and focused*

**Fair:** *we are honest and act with integrity*



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

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 Stephen Browning died on 3 August 2018 from psychoactive substance toxicity. He was found unresponsive in his cell at HMP Leeds. Mr Browning was 42 years old. I offer my condolences to Mr Browning's family and friends.

Mr Browning had a long history of substance misuse in prison and there is evidence that he used psychoactive substances frequently. Mr Browning was offered appropriate support by substance misuse services but he had refused to engage with them over the last six weeks of his life. I am concerned, however, that staff did not always follow instructions in prison policy when they suspected Mr Browning to be under the influence of drugs.

While the prison has taken measures to tackle the issue of drugs, more needs to be done. Mr Browning's death is another example of how dangerous these drugs are and how prisons are struggling to reduce their use.

Mr Browning also had an extensive history of mental health issues which were treated appropriately by Leeds. However, I am concerned that healthcare records did not include a clear plan for Mr Browning's future care.

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**

**June 2019**

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# Summary

## Events

1. In January 2007, Mr Browning was charged with murder and remanded into custody. In September 2007, he was sentenced to life imprisonment with a minimum tariff of over 24 years.
2. Mr Browning was a complex prisoner who was difficult to manage. He was diagnosed with personality disorder, depression and anxiety and was often assessed as a risk to himself, as well as to others. He received a further sentence of 40 months imprisonment in 2014 for assaulting another prisoner. He frequently moved prisons and was segregated due to his disruptive behaviour. He also made several attempts to take his own life.
3. Records indicate that Mr Browning used illicit drugs regularly throughout his time in prison, most notably psychoactive substances (PS). He generally engaged with substance misuse services, although he refused to do so over the last six weeks of his life.
4. Mr Browning returned to HMP Leeds on 13 July, after a brief period at HMP Lincoln, where he had set fire to a cell and been found under the influence of PS. Staff said he seemed happy and more settled than previously. They did not suspect him of using PS. Staff made considerable efforts to engage with him and were in the process of making plans for the longer term, potentially involving a move to another prison nearer his mother.
5. On 2 August, staff and prisoners said that Mr Browning was his usual self. An officer checked him in his cell around 10.00pm and had a short conversation with him. The next morning, at 5.43am, the officer saw Mr Browning lying on the floor of his cell. The officer was initially unsure whether Mr Browning was asleep and asked another officer for her opinion.
6. When they could not get a response from Mr Browning, the officers went into the cell. They officers could not detect a pulse and noted that Mr Browning was cold and stiff. A nurse arrived a few seconds later and assessed Mr Browning. She did not start cardiopulmonary resuscitation since Mr Browning had clearly been dead for some time. Paramedics arrived and, at 6.03am, pronounced Mr Browning dead.

## Findings

### Substance Misuse

7. Mr Browning died from the toxic effects of illicit drugs. There is no evidence that his death was anything other than an accident.
8. Mr Browning received appropriate support for his drug misuse at Leeds.
9. Leeds has an extensive PS policy, with instructions on what staff should do if prisoners are discovered under the influence of illicit substances. We are concerned that these instructions were not always followed.

10. Leeds also has a drug strategy in place and staff are working hard to implement it. However, drugs are still readily available at the prison and more needs to be done to tackle this.

### **Mental health care**

11. Mr Browning's mental health care was of a good standard and equivalent to that which he could have expected to receive in the community. However, some improvement in the quality of healthcare records is needed.

### **Recommendations**

- The Governor should ensure that when a prisoner is suspected to be under the influence of PS, all staff follow the instructions in Leeds' PS policy.
- The Governor should ensure that the key drug issues at Leeds are identified and that the prison's local drugs strategy is revised to ensure that these key issues are being addressed, and published by September 2019, in accordance with HMPPS's objective.
- The Head of Healthcare must ensure that staff record significant decisions about prisoners' care in accordance with the NMC code of conduct for record keeping.

## The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Leeds informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
13. The investigator visited Leeds on 13 August. She obtained copies of relevant extracts from Mr Browning's prison and medical records.
14. The investigator interviewed 12 members of staff and 3 prisoners at Leeds on 25 and 26 September.
15. NHS England commissioned a clinical reviewer to review Mr Browning's clinical care at the prison. The clinical reviewer conducted joint interviews with the investigator.
16. We informed HM Coroner for West Yorkshire of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
17. The investigator contacted Mr Browning's mother to explain the investigation and to ask whether she had any matters she wanted the investigation to consider.
18. Mr Browning's mother asked whether Mr Browning had received the appropriate medication when he was at Leeds, before being transferred to HMP Lincoln. Mr Browning's mother also said that after his father's death, Mr Browning "gave up". She told us that he said he would take his own life. She felt that the Prison Service had not protected her son. She also said that she had not been able to inform staff at Leeds when she had been concerned about her son's welfare. Mr Browning's mother was also concerned that she had not received all of Mr Browning's property after he died. We have addressed all these issues in our report.
19. Mr Browning's mother received a copy of the initial report. She pointed out a factual inaccuracy. This report has been amended accordingly. Mr Browning's mother also raised a number of issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.
20. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies. They commented on one of the recommendations which has been amended to reflect their feedback.

## Background Information

### HMP Leeds

21. HMP Leeds is a local prison holding a maximum of 1,218 men on remand, convicted or sentenced. The prison serves the courts of West Yorkshire. Care UK provides health services, including mental health services. The prison has 24-hour primary healthcare cover.
22. In August 2018, Leeds was selected to be part of the '10 Prisons Project', which seeks to improve safety, security and decency in the prison. The project is focusing on reducing violence, improving living conditions, preventing drugs from entering the establishment and enhancing the leadership and training available to staff.

### HM Inspectorate of Prisons

23. The most recent inspection of HMP Leeds was conducted in November 2017. Inspectors reported that the number of incidents of self-harm was higher than at similar establishments. They found that the quality of ACCT assessments was generally good and that mental health staff routinely attended ACCT reviews, though caremaps were often inadequate, and observations did not demonstrate meaningful interactions.
24. Inspectors found that the demand for mental health services was high and a third of prisoners said that their mental health needs were not met. They found that mental health triage clinics were not used effectively. Inspectors found that the drug supply reduction strategy was reasonable. However, 63% of prisoners said it was easy to get illegal drugs and about a third of prisoners tested positive for drugs, including PS.

### 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 December 2017, the IMB reported that the number of incidents of self-harm had increased compared with 2016, though the new Safer Custody team had taken steps to reduce the incidences of self-harm and suicide. The IMB reported that the mental health team was active throughout the prison and their attendance at ACCT reviews was good.

### Previous deaths at HMP Leeds

26. Mr Browning was the twenty-second prisoner to die at Leeds since January 2015. Ten of these deaths were apparently self-inflicted, nine due to natural causes, one a homicide and one due to taking prescribed and illicit drugs. There have been five subsequent deaths.
27. We have previously made recommendations about the need to reduce the availability of drugs in the prison.

## Assessment, Care in Custody and Teamwork

28. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. 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 to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the actions of the caremap are completed.
29. Enhanced case management can be used to support prisoners whose behaviour is so challenging and disruptive that they need additional case management in order that their heightened or exceptional risk of harm to self, others and/or from others is managed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*.

## Psychoactive Substances (PS)

30. Psychoactive substances (formerly known as 'new psychoactive substances or 'legal highs') are a serious problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.
31. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at the time NPS) and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies. HM Prison and Probation Service (HMPPS) now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements.

## Key Events

### January 2007 – 4 April 2018

32. In January 2007, Mr Stephen Browning was arrested and charged with murder. He was remanded into custody.
33. Mr Browning's mental health had deteriorated before the offence, he had attempted suicide three times and been sectioned under the Mental Health Act. He subsequently absconded from hospital. On the day of the offence, Mr Browning had consumed alcohol and drugs. In September 2007, he was sentenced to life imprisonment with a tariff (the minimum amount of time he had to spend in prison) of 24 years and 126 days. His earliest release date was January 2032.
34. Mr Browning spent time in several prisons. From 2009 onwards, he was under the care of their mental health teams. He self-harmed, had suicidal thoughts and suffered from depression. He was prescribed antidepressants and medication to lessen his anxiety. Mr Browning was intermittently subject to Prison Service suicide and self-harm prevention procedures, known as ACCT. In 2012, he took an overdose of antidepressants.
35. Mr Browning was diagnosed with antisocial personality disorder with psychopathic traits. People with antisocial personality disorder can be particularly challenging, exhibiting traits of impulsiveness, and of irresponsible and often criminal behaviour. Mr Browning was also intermittently prescribed antipsychotic medication.
36. Mr Browning was often in debt to other prisoners after buying their prescribed medication from them illicitly. He was an aggressive and challenging prisoner to manage, and was sometimes segregated because of his risk to others. In June 2014, he seriously assaulted another prisoner. He was sentenced to 40 months imprisonment to be served consecutively to his existing sentence. His earliest release date was recalculated as September 2033.
37. During 2016, Mr Browning said he wanted to be dead. He swallowed razor blades and bleach. His risk to himself was deemed such that he was intermittently subject to constant supervision by staff. On 21 September, he transferred to HMP Preston, in line with his wishes, as he wanted to be nearer his father who had been diagnosed with terminal cancer.
38. In January 2017, Mr Browning told healthcare staff that he was having violent thoughts about other prisoners and that "when he snaps he would kill someone." He said he could not control his violent thoughts. He was referred to a psychiatrist and prescribed quetiapine (an antipsychotic medication).
39. In April 2017, Mr Browning transferred to HMP Full Sutton. On arrival, a drug dog gave a positive indication that Mr Browning was in possession of drugs. He told staff that he had taken PS the night before and illicit Subutex (a medication prescribed to manage opiate withdrawal) that morning.

40. On 10 May, Mr Browning's father died. Staff informed Mr Browning, checked his well-being and a doctor prescribed him zopiclone to help him sleep. He attended his father's funeral the following month.
41. Mr Browning subsequently engaged with substance misuse services. He told a sentence planning board in September that he recognised he had not made sufficient progress since being in prison and had found his father's death hard to cope with. Mr Browning said he now wanted to progress, and to transfer to a prison nearer his mother so she could visit him.
42. In October, Mr Browning was diagnosed with cervical spondylosis (wear and tear of the cartilage and bones in the neck). He was prescribed gabapentin to treat the nerve pain. Mr Browning also had hypertension (high blood pressure) and was prescribed ramipril to treat this.
43. On 9 November, staff opened an ACCT as Mr Browning said that he had swallowed batteries and razor blades. He also had a noose and said he was close to taking his own life. He said he wanted to transfer to another prison and was upset over the death of his father. The ACCT was closed a week later and Mr Browning was transferred to HMP Manchester, in line with his wishes.
44. On 2 December, staff opened another ACCT after Mr Browning swallowed razor blades and batteries. He was admitted to hospital until 28 December as a result. He told staff he had swallowed the items because he had been asked to look after an illicit mobile telephone for another prisoner who he would not name.
45. On 25 January 2018, staff suspected that Mr Browning was under the influence of PS, administered through his vape. In February 2018, Mr Browning was subject to constant supervision after he again swallowed batteries and razor blades and said he had planned how he would take his own life. He said he could not handle life or being in prison.
46. On 7 February, a psychiatrist assessed Mr Browning. The psychiatrist considered that Mr Browning was suffering from a major depressive episode and had a moderate to severe anxiety disorder. The psychiatrist noted that he had emotionally unstable personality disorder (EUPD) and needed psychological input to assist him develop coping strategies. EUPD is characterised by strong emotions, mood swings, feelings of being unable to cope and a tendency to self-harm or use drugs and alcohol as a way of coping.

#### **HMP Leeds: 4 April – 29 June 2018**

47. On 4 April, Mr Browning transferred to HMP Leeds so that his mother could visit him more easily. He remained subject to ACCT procedures and was referred to the mental health team.
48. On 10 April, staff suspected Mr Browning was under the influence of PS. The next day staff closed Mr Browning's ACCT.
49. On 14 April, Mr Browning appeared under the influence of PS and staff radioed a code blue emergency. (This is an emergency code indicating that a prisoner has stopped breathing or is unconscious.) His condition improved with treatment from healthcare staff. On 17 April, Mr Browning told a substance misuse worker

that he had not been under the influence of PS on 14 April and had no issues with PS. On 23 April, Mr Browning tested positive for PS.

50. On 27 April, Mr Browning was verbally abusive to a mental health nurse and was discharged from the mental health team. Mr Browning's mother telephoned the prison and spoke to an officer in the safer custody department. She was concerned about Mr Browning, having spoken to him the day before, and told staff that the anniversary of Mr Browning's father's death fell on 10 May. Staff contacted the chaplaincy department which visited Mr Browning and informed wing staff of Mr Browning's mother's concerns.
51. On 30 April, Mr Browning did not collect his medication. A member of pharmacy staff spoke to him and he said he did not want to take his medication. Staff explained the dangers of stopping his medication but Mr Browning said he thought he did not need the medication anymore. He signed a medication refusal form.
52. On 1 May, Mr Browning damaged prison property. He said he was being threatened on the wing and needed to move. On 8 May, staff suspected he was under the influence of PS.
53. On 10 May, he was assaulted by another prisoner but would not identify him. Mr Browning moved wings. Mr Browning's mother telephoned the prison and left a voicemail on the safer custody line. She said she was concerned about Mr Browning as it was the first anniversary of his father's death and he had been upset when they spoke earlier. A member of staff spoke to him. He said he was finding it hard but was coping. The next day the same member of staff returned to talk to Mr Browning who said that he was glad that the anniversary had passed. Mental health staff were also informed and planned to see Mr Browning the following week. Staff telephoned Mr Browning's mother to update her.
54. On 12 May, Mr Browning told staff that he wanted to end his life and there was no longer any point in him being alive. He had also made a noose. Staff opened an ACCT and placed Mr Browning under constant observation. Mental health staff also assessed Mr Browning.
55. On 16 May, Mr Browning told his offender supervisor that he wanted to engage with substance misuse work, so they referred him to the team. On 17 May, Mr Browning said he did not want to attend his appointment with a psychiatrist as he could not be bothered. Due to concerns that Mr Browning was using PS, his prescription of antipsychotics and antidepressants had been stopped (because of the dangers of taking them while also using PS). Mr Browning failed to attend his appointment with the substance misuse team.
56. On 18 May, Mr Browning said he felt much better and his ACCT observations were reduced. On 19 May, Mr Browning swallowed batteries and a razor. He said he wanted to return to HMP Manchester. He was later assaulted by another prisoner over a debt he had failed to pay. He said he did not want to move wings as he would also be under threat on the other wing. He later refused to leave the exercise yard and was found in possession of an improvised weapon which he said was for self-defence. He was placed in the segregation unit as a result and staff held an ACCT review.

57. A Reverend visited Mr Browning daily as part of his chaplaincy duties in the segregation unit. He said that Mr Browning seemed “agitated, frustrated and a bit depressed”. He said that over time, Mr Browning relaxed, became good humoured and said he wanted to transfer to Manchester. He said it was easier for his mother to visit him in Leeds but he felt more comfortable at Manchester as he had spent more time there. The Reverend also spoke to Mr Browning’s mother during this time. She had concerns that Mr Browning was a risk to himself and she wanted to meet with prison staff.
58. Mr Browning was subject to a Challenge Support Intervention Plan (CSIP). Leeds was one of several prisons piloting CSIPs at the time. CSIPs are for any prisoners who are thought either to be violent towards others or to need support themselves. Mr Browning’s CSIP said that staff were to encourage him to associate with other prisoners (once he was moved from segregation), for him to return to a standard residential wing, to consider his transfer to another prison and for him to engage with his key worker.
59. On 24 May, Mr Browning began taking his prescribed medication again. This was quetiapine, gabapentin and ramipril. Mr Browning told healthcare staff he had started to feel better. On 29 May, staff closed Mr Browning’s ACCT. This was reopened on 2 June after Mr Browning cut his arm and took an overdose, stating that this was an attempt to take his life. He said he was sick of prison and his lack of progress. When checking that he had no more medication in his possession, staff found an improvised pipe for smoking PS in his cell.
60. On 9 June, Mr Browning set fire to his cell and was again segregated as a result. He said he thought it would help him get transferred to Manchester. He said he felt unsafe at Leeds due to having issues with other prisoners. Mr Browning told staff that he preferred being in the segregation unit rather than on a standard wing. He also told a substance misuse worker that he did not want to engage with them. On 14 June, staff closed Mr Browning’s ACCT.
61. The acting Deputy Governor, told the investigator that Manchester was not willing to accept Mr Browning for transfer because of his past behaviour at the prison. He said that following this refusal, Mr Browning asked to go to HMP Lincoln. He contacted Lincoln, who agreed to take him on the basis that if he did not settle at the prison he would be returned to Leeds.
62. On 29 June, a psychiatrist noted that Mr Browning had requested an increase in his prescription of quetiapine (his antipsychotic medication). The psychiatrist noted that he would need to see Mr Browning before increasing his prescription and that this would now need to happen at HMP Lincoln where Mr Browning was due to transfer later that day.

#### **HMP Lincoln: 29 June – 13 July 2018**

63. On 29 June, Mr Browning transferred to HMP Lincoln. He was taken to the segregation unit on arrival. The next day, staff found Mr Browning in his cell under the influence of drugs. Healthcare staff who attended noted that he was unconscious but responsive to touch. They administered oxygen and placed Mr Browning in the recovery position. Mr Browning refused treatment from paramedics.

64. On 6 July, Mr Browning set fire to his cell. He said he did not want to be at Lincoln. He said he had no thoughts of suicide and self-harm. Staff agreed that he would return to Leeds in accordance with the agreement between prison managers. Mr Browning was polite and engaged with staff over the following week.

### **HMP Leeds: 13 July – 2 August 2018**

65. On 13 July, Mr Browning returned to Leeds. A Custodial manager (CM) drove the bus that transported Mr Browning. Mr Browning told the CM that he was happy to be returning to Leeds.
66. The duty Governor, did not want Mr Browning to return to the segregation unit as he wanted to give him the opportunity to prove that he could comply with prison rules. He arranged for Mr Browning to be located on the first night centre for the foreseeable future and to be employed as a painter. He ultimately wanted Mr Browning to be transferred closer to his mother and began considering potential options. The CM understood that this was one of the reasons Mr Browning was located on the first night centre as it was not expected that he would be at Leeds long. Mr Browning himself did not want to move to a standard residential wing as he said he would be under threat from other prisoners.
67. Shortly after his arrival at Leeds, a nurse spoke to Mr Browning through the observation panel in his cell door. It was not possible to unlock him as he had arrived too late in the evening. She was satisfied that there were no urgent issues that needed to be dealt with and he would be safe overnight. She said Mr Browning was calm and polite.
68. A nurse assessed Mr Browning the next morning. He refused to be referred to the substance misuse service. The nurse referred him to the mental health team, noting that he had a history of depression and self-harm and had attempted suicide in the past. The nurse noted that he could not get a urine sample from Mr Browning to test for drugs but that Mr Browning had a history of PS use. On 15 July, a nurse completed a secondary healthscreen.
69. Mr Browning signed a bespoke first night centre compact. This said that Mr Browning would have the opportunity to exercise between 8.00am-8.30am every morning. After this he would have the opportunity to shower and use the telephone. He would then paint the wing until midday. Other than this, he would be locked in his cell. Mr Browning agreed that he would not threaten anyone, would not cause disruption and would comply with staff instructions. The regime was an attempt to give structure to Mr Browning's day. The CM said that Mr Browning was a keen painter and made himself very useful during his time there.
70. On 16 July, a mental health nurse noted that she had received the mental health referral from a nurse. The mental health nurse booked Mr Browning an appointment for mental health triage the next day. Mr Browning did not attend this appointment at 9.00am. A nurse called the wing to speak to Mr Browning about whether he wanted an appointment with the mental health team. Mr Browning was rude and abusive to staff and said he did not want to attend.

71. At 12.00pm, Mr Browning asked the mental health nurse who was on the wing, for an increase in his prescription of quetiapine. The nurse said she needed to discuss this with a psychiatrist. She was unaware that Mr Browning had missed his mental health appointment with another mental health nurse that morning. She sent an electronic message to a psychiatrist, asking him to review Mr Browning. Mr Browning was added to the psychiatrist's waiting list.
72. At 1.15pm, Mr Browning was discussed at the mental health team meeting. The team manager, noted that he had failed to attend his appointment with a nurse and recorded "*follow up?*". The mental health nurse was not at the meeting.
73. The CM told the investigator that Mr Browning seemed happy located on the first night centre, and that he never raised any concerns. He had a good relationship with the prisoners who were cleaners on the wing as they were the only other prisoners who generally stayed there longer than one night. The CM said that he never had any concerns that Mr Browning was under the influence of drugs. The Head of Residence and Safety also said that as Mr Browning seemed to be coping well on the first night centre, they decided to keep him located there.
74. The mental health nurse said she saw Mr Browning informally most days that she was working at the prison. She said he did not seem down, was always polite to her and never seemed to be under the influence of PS.
75. The Reverend said that Mr Browning seemed settled and liked living on the first night centre. His appearance was noticeably different to how he had looked at Leeds in the past. The Reverend said he was quite "bright, bubbly and chatty" and seemed to get on well with other prisoners and staff on the wing. He never had any concerns he was under the influence of drugs.
76. A prisoner and wing cleaner, said that Mr Browning seemed happy to be located on the first night centre and got on well with other prisoners. The prisoner said that Mr Browning was stressed by the length of his sentence and he sometimes had concerns that he was a risk to himself. He said he did not know if Mr Browning used PS but he did sometimes appear to be "high".
77. Another prisoner and wing cleaner, also said that Mr Browning seemed happy to be located on the first night centre. He said he was not aware of Mr Browning being under the influence of drugs.
78. On 23 July, his offender supervisor, introduced himself to Mr Browning. They discussed why Mr Browning had returned to Leeds and his plans for progression. The Head of Residence and Safety told the investigator he recalled talking to Mr Browning around 30 July about how well he was doing on the first night centre and told him that they were not going to relocate him to a standard wing.
79. On 1 August, The Head of Safety received a letter from Mr Browning's mother asking to see him as she was concerned about her son. He said he intended to contact her after her return from holiday on 4 August.

## Events of 2 and 3 August

80. The mental health nurse told the investigator that she saw Mr Browning while he was painting on the afternoon of 2 August. She said they joked with each other and he seemed his usual self.
81. A prisoner arrived at Leeds that day and was placed in a cell next door to that of Mr Browning. That evening, Mr Browning spoke to him through his observation panel and asked if he had any vape liquid, which he gave him. Mr Browning told him to be careful as there was PS in the prison and another prisoner had suffered side effects that day from taking it. He did not think Mr Browning had been taking PS. He said it was about 7.30pm and, at the end of the conversation, Mr Browning said he would see him in the morning and give him some coffee and sugar.
82. Around 8.00pm, after all the other prisoners were locked in their cells, a prisoner and another prisoner gave prisoners their tea packs. He said that Mr Browning had seemed a bit drowsy when they gave him his.
83. An officer was working on the first night centre that night. Between 9.45pm and 10.00pm he checked all the prisoners on the wing. When he did so, Mr Browning asked him what time the lights on the landing would be turned off. The officer said this was not an unusual question for Mr Browning to ask since he did not like the light shining through his observation panel. The officer told him he would switch them off shortly. He said that there was nothing out of the ordinary in Mr Browning's demeanour.
84. On 3 August, around 5.30am, the officer began his roll count. When he reached Mr Browning's cell at 5.43am, he saw that Mr Browning was lying on the floor. This did not concern him at first as he said it was not unusual for prisoners to sleep on the floor, as they often find it more comfortable. At that point, another officer who was working in the wing office, shouted to the officer. He went to the office and told the officer that he was in the middle of doing his roll count.
85. The officer went back to Mr Browning's cell less than a minute after he had first looked in. He shone his torch into the cell and could not see any movement. He shouted to Mr Browning, but he did not respond. After looking into the cell for two minutes, he went to the wing office. He asked the other officer to accompany him to Mr Browning's cell to check on him as he was lying on the floor and he could not see whether Mr Browning was breathing. The two officers returned to the cell 30 seconds later and an officer kicked the door and shouted Mr Browning's name.
86. As they were unable to get any response, an officer radioed a code blue medical emergency. An officer broke open his emergency pouch containing a cell key and unlocked Mr Browning's cell. This was one minute after they had both returned to the cell and over four minutes after the officer had first looked in. Staff in the control room telephoned an ambulance immediately. (This was subsequently confirmed with the investigator by email and an apparent four-minute delay documented was due to differing times recorded on the telephone system and clock.)

87. An officer touched Mr Browning's leg, which was cold. He checked for a pulse but could not detect any. The officer noticed there was a vape by Mr Browning's hand. The other officer said that when the officer touched Mr Browning's leg, his whole body seemed to move as it was rigid. Mr Browning was also grey in colour. She said she thought Mr Browning was dead. She came out of the cell and a nurse arrived seconds later.
88. The nurse told the investigator that Mr Browning looked obviously dead, his skin was mottled and he was cold to the touch. She said that there was no point in attempting CPR as it would have been futile and undignified for Mr Browning. Officers locked the door with Mr Browning inside the cell and waited for the paramedics to arrive. Paramedics arrived at 6.00am, assessed Mr Browning and pronounced him dead at 6.03am.

### **Contact with Mr Browning's family**

89. At 6.55am, a Supervising Officer (SO) was appointed as family liaison officer (FLO). After making address checks with the police, the SO went to Mr Browning's mother's address at 9.00am, along with the Reverend and The Head of Safety. As there was no reply, they went to Mr Browning's brother's address where there was also no reply. They returned to Mr Browning's mother's address but still got no reply. They returned to the prison and tried telephoning several numbers recorded on Mr Browning's record. Mr Browning's mother answered one of these and they arranged to meet her at her house at 2.00pm.
90. The FLO, the head of safety and the Reverend went to Mr Browning's mother's address and broke the news of her son's death. The FLO remained in contact with Mr Browning's mother and sister over the following weeks and offered a contribution to Mr Browning's funeral expenses in line with prison service instructions. The Reverend conducted Mr Browning's funeral and remained in contact with Mr Browning's mother afterwards.
91. The FLO returned Mr Browning's property to his mother. This included all the property listed on his property cards when he arrived at Leeds and Lincoln prisons. The FLO told the investigator he had no evidence of any other outstanding property.

### **Support for prisoners and staff**

92. After Mr Browning's death, the Governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
93. The prison posted notices informing other prisoners of Mr Browning'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 Browning's death.

### **Post-mortem report**

94. The post-mortem report said that there were no signs of self-harm and that the most likely cause of Mr Browning's death was PS toxicity. There was evidence that Mr Browning had used PS in the hours before he died. Mr Browning's body showed signs of pulmonary oedema (excess fluid in the lungs which makes it

difficult to breathe). It was noted that this is commonly seen in deaths caused by drug toxicity. The pathologist said that the reddening of Mr Browning's airways may have been due to the inhalation of PS.

95. Tramadol (a painkiller), ibuprofen, gabapentin, benzodiazepine (a sedative), quetiapine and cannabis were also detected in Mr Browning's system but the pathologist concluded that they were unlikely to have contributed to his death.

# Findings

## Substance misuse

96. The PPO's Learning Lessons Bulletin on PS, issued in July 2015, highlighted that PS was then becoming a source of increasing concern in prisons. Not only does PS use have a profoundly negative impact on physical and mental health, but trading these substances can lead to debt, violence and intimidation. Mr Browning's death is a clear example of how dangerous PS is and illustrates why prisons must do all they can to eradicate its use.
97. The toxicology investigation found other drugs in Mr Browning's system, including cannabis, tramadol and benzodiazepine which he had not been prescribed, but which did not contribute to his death. It must be concluded that he also obtained these drugs illicitly.
98. Mr Browning had a long history of substance misuse. He was found under the influence of PS on several occasions during the last months of his life. He had been engaging with substance misuse services in many of the prisons he had been in and had done so at Leeds until 13 June, when he refused any further appointments. This continued when he returned to Leeds on 14 July.
99. Staff on the first night centre at Leeds did not know that Mr Browning was a PS user and told the investigator that they did not see him under the influence. However, one prisoner said that Mr Browning frequently looked "high" during this period. The wing observation book for the two days before Mr Browning died contains references to modified vapes being found on the wing and to another prisoner suspected to be under the influence of PS.
100. Leeds PS policy, issued in February 2018, contains clear instructions on what staff must do if they suspect a prisoner to be under the influence of PS. This includes contacting healthcare staff, reporting all incidents to the duty manager, submitting an intelligence report and removing all paper from the prisoner's cell and taken to security for testing. The duty manager should then record all actions in a prisoner's record and consider disciplinary action or other sanctions. A mandatory drug test may also be completed.
101. We are concerned that this policy does not seem to have been followed consistently at Leeds before Mr Browning moved to Lincoln in June 2018. For example, intelligence reports were not always submitted in relation to Mr Browning's suspected PS use and there is no evidence that any paper was ever removed from his cell. We make the following recommendation:

**The Governor should ensure that when a prisoner is suspected to be under the influence of PS, all staff follow the instructions in Leeds' PS policy.**

102. To reduce the amount of PS coming into the prison through the post, Leeds is photocopying all letters to prisoners, apart from those sent through Rule 39 (confidential legal post). Rule 39 mail will also be tested for PS where there is reasonable suspicion. The Head of Reducing Reoffending, said the prison is installing grilles on every window to reduce the amount of drugs coming into

prison via drones. The prison is also in the process of purchasing a scanner to detect packages secreted on a person.

103. We accept that the prison has a drug strategy in place and staff are working hard to implement it. Nevertheless, the Mr Brown was apparently able to obtain PS, cannabis and illicitly traded prescription drugs at Leeds without difficulty and Mr Browning's death was a tragic consequence of this ready availability. It is clear, therefore, that more needs to be done to reduce both the supply and the demand for PS.
104. Leeds is not alone in facing this problem – it is a serious problem across much of the prison estate. Individual prisons are, for the most part, doing their best to tackle the problem by developing their own local drug strategies. Further to calls from the PPO, HMPPS has published new national guidance to prisons providing evidence-based advice on what works. We welcome the fact that such guidance was issued in April 2019, together with a Prison Service strategy to reduce the supply of and demand for drugs in prisons.
105. In relation to reducing the supply of drugs, the new Prison Service strategy says:

“Every prison is different, and will benefit from tools to assess their specific security needs. We have worked with prisons to carry out Vulnerability Assessments in prisons to build a picture of the security risks and enable establishments to better target their resources to tackle them. This resource will continue to be offered across the estate. The Drug Diagnostic toolkit used for the prisons in the 10 Prisons Project has also proved to be useful in identifying key issues in different establishments and so we will share this for use across the whole estate, supporting prisons to identify where changes could have the greatest impact.”

We, therefore, recommend:

**The Governor should ensure that the key drug issues at Leeds are identified and that the prison's local drugs strategy is revised to ensure that these key issues are being addressed, and published by September 2019, in accordance with HMPPS's objective.**

### Assessment of risk and ACCT management

106. Mr Browning had, rightly, been assessed as being a risk to himself at times. He was supported by ACCT procedures on numerous occasions throughout the eleven years he had been in prison. The last of these ACCTs was closed on 14 June.
107. When Mr Browning returned to Leeds in mid-July, staff went to considerable efforts to locate him where he felt safe and to provide him with employment to keep him occupied. Staff members we spoke to all said that he seemed settled, he was complying with the regime and they had no concerns about him. We are satisfied that there was nothing to suggest that Mr Browning posed a risk to himself after this date and that there was, therefore, no reason for Mr Browning to have been subject to suicide and self-harm monitoring at the time of his death.

## Clinical Care

### *Mental health care*

108. The clinical reviewer concluded that Mr Browning's mental health care was of a good standard and equivalent to that which he could have expected to receive in the community.
109. Mr Browning had a long history of mental health issues including self-harm, attempted suicide, depression and personality disorder. He was a complex prisoner who received significant input from mental health services. When he returned to Leeds on 13 July, he was appropriately referred to the mental health team. Mr Browning failed to attend his subsequent appointment on 17 July. A nurse contacted him via wing staff to follow up why he had missed the appointment but he was rude and abusive.
110. The same day, staff discussed Mr Browning at a mental health team meeting. We share the clinical reviewer's view that the notes from this meeting are inadequate and do not clearly document the plan for Mr Browning's future mental health treatment. The Head of Healthcare, acknowledged this to the investigator.
111. In the absence of any formal mental health treatment after Mr Browning returned to Leeds, a nurse saw him on the wing most days she was working. She had no concerns about him and added Mr Browning to the psychiatrist's waiting list when he requested an increase in his antipsychotic medication. At the time, there was a waiting time of 50 days to see the psychiatrist. We were told that since that time the number of clinics has doubled and the waiting time has been much reduced.
112. While the overall standard of Mr Browning's mental health care was good, we are concerned that there were some omissions in record keeping. We make the following recommendation:

**The Head of Healthcare must ensure that staff record significant decisions about prisoners' care in accordance with the NMC code of conduct for record keeping.**

### *Physical healthcare*

113. Mr Browning had hypertension and cervical spondylosis but was not referred to the long-term conditions clinic when he returned to Leeds, as he should have been. This would have ensured that his quetiapine (antipsychotic medication) was monitored. As a result, the clinical reviewer concluded that Mr Browning's physical healthcare was not equivalent to that which he could have expected to have received in the community. However, the clinical reviewer also notes that Mr Browning might not have been seen in the two weeks before he died even if he had been referred.
114. The review completed by Care UK shortly after Mr Browning's death identified the failure to refer Mr Browning to the long-term conditions clinic and the Head of

Healthcare told us that the process has now been amended so that referrals are not missed in future. We therefore make no recommendation about this.

### **Contacting safer custody**

115. Mr Browning's mother said that she received no response from the main switchboard when she called the prison on the anniversary of Mr Browning's father's death on 10 May. She said she telephoned the visitors' centre, which passed on her concerns to the relevant staff.
116. Although it is unfortunate that no one answered her call to the main prison number, The Head of Safety said that there is a dedicated safer custody telephone number for concerned family and friends. This has voicemail capability and is regularly monitored throughout the day. This number is both on the prison website and advertised in areas of the prison accessed by visitors.
117. We are satisfied that Mr Browning's mother's voicemail was picked up and that a member of staff spoke to Mr Browning in response that day and again the next day, and that Mr Browning's mother was updated.

### **Emergency response**

118. Over four minutes passed between an officer first looking into Mr Browning's cell and his unlocking the cell door.
119. The officer left the cell for under a minute when another officer called him to the wing office. We accept that at the time he had not realised there was an emergency and thought Mr Browning was sleeping on the floor.
120. When he returned to the cell, the officer told the investigator that he was not sure whether his "eyes were tricking me" when he could see no signs that Mr Browning was breathing. He said that Mr Browning was lying on his side in what looked like a comfortable position, like the recovery position, and looked asleep. He wanted the opinion of another officer before opening the door, and for his own safety. The officer told the investigator that he would consider going into a cell on his own in a life-threatening situation if he had assessed it as safe to do so. He was uncertain, at the time, whether this was a life-threatening situation or that it was safe to do so.
121. The officer returned to the cell with another officer. They unlocked the door a minute later when they still got no response. On balance we consider that the delay in unlocking Mr Browning's cell was understandable in the circumstances.
122. Even if they had gone into the cell earlier, it would not have affected the outcome for Mr Browning. When staff found Mr Browning, he had mottled skin, was cold to the touch and rigor mortis had begun to set in, indicating that he had been dead for some time. Staff decided not to attempt to resuscitate Mr Browning. The clinical reviewer comments this was the correct, and most dignified, decision in accordance with NHSE protocol. We agree with this conclusion.



**Prisons &  
Probation**

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