

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Filmon Brhane, a prisoner at HMP Maidstone, on 12 June 2023

A report by the Prisons and Probation Ombudsman

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OUR VISION

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

WHAT WE DO



WHAT WE VALUE



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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.

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

Mr Filmon Brhane died on 12 June 2023 after being found hanged in his cell at HMP Maidstone. He was 23 years old. I offer my condolences to Mr Brhane's family and friends.

Mr Brhane was due for release on 16 June but knew he might be further detained at Maidstone under immigration powers, pending his possible deportation. He was distressed about the prospect of deportation and staff managed him under suicide and self-harm prevention procedures (known as ACCT) on three occasions, including at the time he died.

Although ACCT procedures were largely well managed, there were some deficiencies. Immigration staff were not sufficiently involved in ACCT case reviews, care maps were not updated, and Mr Brhane's ACCT document did not always travel with him around the prison. In addition, the immigration team did not note their contacts with Mr Brhane on his prison record or speak to staff when they gave Mr Brhane information about his immigration status.

The clinical reviewer concluded that the physical and mental healthcare Mr Brhane received at Maidstone was of a reasonable standard and equivalent to that which he could have expected to receive in the community.

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

Adrian Usher
Prisons and Probation Ombudsman

May 2024

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Summary

Events

1. On 16 December 2022, Mr Filmon Brhane was sentenced to 12 months imprisonment and taken to HMP Elmley. This was his first time in prison. Mr Brhane was an Eritrean national who had been living in the UK since he was 14 years old.
2. In January 2023, Mr Brhane transferred to HMP Maidstone, a prison for foreign national prisoners. He had a history of substance misuse, post-traumatic stress disorder (PTSD) and mental health problems.
3. Mr Brhane was due to be released on 16 June 2023, but knew he might be further detained at Maidstone under immigration powers, and that, ultimately, he might be deported from the UK.
4. During his time at Maidstone, Mr Brhane was supported under ACCT procedures on three occasions, in March, May and June. On all three occasions he reported that he heard voices telling him to kill himself and he was worried that he might be deported. The Home Office immigration team only attended one of Mr Brhane's ACCT reviews in March and although they had further contact with him, did not record this in his prison or ACCT records. Mr Brhane was being supported by ACCT procedures when he died.
5. On the evening of 12 June, a prison officer found Mr Brhane hanged in his cell. Prison and healthcare staff provided emergency care. At 8.30pm, paramedics confirmed that Mr Brhane had died.

Findings

6. Mr Brhane had several risk factors for suicide and self-harm. It was his first time in prison, he was a foreign national prisoner, he had a history of substance misuse, PTSD and mental health problems. His risk had been identified and he was being supported by ACCT procedures at the time of his death. We found that although the ACCT procedures were largely well-managed, immigration staff were not sufficiently involved in ACCT case reviews, care maps were not updated and sometimes Mr Brhane's ACCT document did not travel with him round the prison.
7. We also found that immigration staff did not note their contact with Mr Brhane in prison records or adequately consider the impact of the information they gave him on his state of mind.

Recommendations

- The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including that:
 - staff set specific and meaningful caremap actions, identifying who is responsible for them and reviewing progress at each review;

- staff consistently invite the HOIE team to contribute to ACCTs where immigration issues are relevant; and
- staff ensure ACCT documents travel with prisoners when they leave the wing.
- The Deputy Director of Immigration Prison Teams (North and South) should ensure that HOIE staff:
 - share and record their contact with prisoners (and detainees) in prison records, including ACCT documents;
 - are involved in the ACCT process, including reviews, if there are concerns about a prisoner's immigration or deportation status, and
 - consider how information relating to immigration status or possible deportation is delivered to prisoners and whether it might increase the risk of suicide or self-harm.
- The Governor and Deputy Director of Immigration Prison Teams (North and South) should review current processes for the sharing of information between prison and Home Office staff at Maidstone and share their findings with the Ombudsman.
- The Governor should ensure that staff provide all relevant information requested by the Prison and Probation Ombudsman's office, including a prisoner's telephone calls, in line with PSI 58/2010.

The Investigation Process

8. The PPO was notified of Mr Brhane's death on 13 June 2023. The investigator issued notices to staff and prisoners at HMP Maidstone informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
9. The investigator obtained copies of relevant extracts from Mr Brhane's prison and medical records.
10. NHS England commissioned a clinical reviewer to review Mr Brhane's clinical care at the prison. The investigator and clinical reviewer conducted joint interviews with ten members of staff.
11. We informed HM Senior Coroner for Mid Kent & Medway of our investigation. She gave us the results of the post-mortem examination. We have sent her a copy of this report.
12. The Ombudsman's family liaison officer contacted Mr Brhane's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. The family raised no specific questions. While Mr Brhane had told prison staff that his name was "Filimon", his family have confirmed it was "Filmon". Mr Brhane's parents also confirmed that when Mr Brhane was in prison, he had contacted them and his sister by telephone, approximately every fortnight.
13. Mr Brhane's family received a copy of the initial report. The solicitor representing the family wrote to us and provided some additional information that has been reflected in this report.
14. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Maidstone

15. HMP Maidstone is a training prison that holds 579 foreign national prisoners. Almost all the population is of interest to Home Office Immigration Enforcement (HOIE) which has a team, called the In Prison Team (IPT) on site in the prison.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Maidstone was in October 2022. Inspectors reported prisoners' anxiety had increased due to Home Office delays in processing their immigration cases. The rate of self-harm had increased since the last inspection. Inspectors found that staff had not received enough training in the revised ACCT process and the quality of support was not high. ACCT care plans were often missing or incomplete and in many neither risks and triggers nor sources of support had been identified. More prisoners than at the previous inspection said they felt unsafe. Many attributed this to their uncertain immigration status, but others raised concerns about debt and antisocial behaviour.

Independent Monitoring Board

17. 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 February 2022, the IMB raised significant concerns about the reduced level of contact that foreign national prisoners had had with the immigration team during the pandemic and the service they received from the Home Office. The community council and chaplaincy said this caused stress and anxiety leading to self-harm and other negative behaviours by some prisoners. The number of prisoners held under IS91 provisions (authority to detain under Immigration Act powers after completing their sentence) had significantly increased and the IMB concluded that more needed to be done to improve this situation. The IMB said it was essential that HMPPS and the immigration team work better together to ensure that these issues were addressed.

Previous deaths at HMP Maidstone

18. Mr Brhane was the fourth prisoner to die at Maidstone since 1 June 2020. Two of the previous deaths were from natural causes and the other was a homicide. There were no similarities between these deaths and Mr Brhane's. There has been one further self-inflicted death since that of Mr Brhane which we are currently investigating.

Assessment, Care in Custody and Teamwork (ACCT)

19. Assessment, Care in Custody and Teamwork (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.

20. As part of the process, a care plan (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the care plan have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key worker scheme

21. 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 engaging with people, building better relationships between staff and prisoners, and helping people settle into life in prison. Details of how the scheme should work are set out in HMPPS's Manage the Custodial Sentence Policy Framework. This says:
 - 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.
 - Key workers must have completed the required training.
 - 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.
 - Within this allocated time, key workers can vary individual sessions in order to provide a responsive service, reflecting individual need and stage in the sentence. A key worker session can consist of a structured interview or a range of activities such as attending an ACCT review, meeting family during a visit or engaging in conversation during an activity to build relationships.
22. In 2023/24, due to exceptional staffing and capacity pressures in parts of the estate, some prisons are delivering adapted versions of the key work scheme while they work towards full implementation. Any adaptations, and steps being taken to increase delivery, should be set out in the prison's overarching Regime Progression Plan which is agreed locally by Prison Group Directors and Executive Directors and updated in line with resource availability.

Key Events

23. On 16 December 2022, Mr Filmon Brhane was sentenced to 12 months in prison for offences of burglary and possession of a knife. He was taken to HMP Elmley. Mr Brhane was an Eritrean national. It was his first time in prison. He had refugee status and the right to remain in the UK.
24. A nurse completed Mr Brhane's reception health screen. He told the nurse that he had no history or current thoughts of suicide or self-harm but had post-traumatic stress disorder (PTSD – someone who often relives a traumatic event through nightmares and flashbacks, and may experience feelings of isolation, irritability and guilt). Mr Brhane said he had been under the care of the community Early Intervention in Psychosis (EIP) crisis team. This team works with people who are experiencing their first episode of psychosis and/or who have been experiencing symptoms for less than three years. Mr Brhane said he was not taking any medication.
25. Another nurse reviewed Mr Brhane's medical record and noted that he had a history of suicidal ideation and had previously been prescribed risperidone (an antipsychotic medication used to treat schizophrenia and bipolar disorder). The nurse referred Mr Brhane to the mental health team. On 19 December, a mental health nurse reviewed Mr Brhane's medical records and noted that he had a mental health disorder, possibly schizophrenia.
26. The next day, a mental health nurse assessed Mr Brhane. Mr Brhane said he had no history of attempted suicide, self-harm, or substance misuse, despite his medical records indicating that he had previously used illicit substances and self-harmed. Mr Brhane said he had no concerns about his mental health. He said that his family lived in the Netherlands, that he had no friends and was homeless. The nurse noted that Mr Brhane would be monitored by the mental health team and booked an appointment for him to see a psychiatrist.
27. On 10 January 2023, a mental health nurse saw Mr Brhane. Mr Brhane talked about fleeing Eritrea, at the age of 14, with his cousin, and travelling by boat to the UK. He stated that this experience led to his PTSD, although Mr Brhane's medical summary care record stated he had psychosis due to cannabis use. Mr Brhane denied that he had used any illicit substances since he had been in prison. He said he had no thoughts of suicide or self-harm. He said that although he had previously taken risperidone, he was not currently prescribed any medication.
28. The next day, a psychiatrist, a mental health nurse and Mr Brhane's community mental health nurse assessed him. They noted that Mr Brhane had a history of persecutory beliefs and visual hallucinations. However, he had no current psychotic symptoms, no thoughts of suicide or self-harm and had had no emotional or behavioural problems in prison. It was noted that he had stopped taking his medication due to his imprisonment. The team agreed that Mr Brhane would be prescribed a low dose of risperidone, and this would be reviewed in two months' time.

HMP Maidstone

29. On 25 January, Mr Brhane transferred to HMP Maidstone. The Person Escort Record (PER) noted that Mr Brhane was prescribed antipsychotic medication and had no next of kin. Staff did not record any concerns about his risk of suicide or self-harm.
30. Contrary to his recorded history, Mr Brhane told staff that he had no mental health concerns and had not engaged with mental health services. He denied that he had any history of attempted suicide, self-harm or substance misuse. He said that he was from Eritrea and had no known family. He did not name a next of kin. Mr Brhane also told a nurse he had no thoughts of suicide or self-harm. The nurse noted he was prescribed antipsychotic medication, which was continued, and referred him to the mental health team.
31. On 27 January, Mr Brhane told staff that his mental health was “in a bad way”, that he was anxious and struggled with the prison regime. Staff referred him to psychology services and booked him to attend a trauma workshop on 7 February. Mr Brhane failed to attend, and staff did not record any reason for his absence. The same day, Mr Brhane found the contact details for his cousin, who lived in the UK, got him added to his allowed numbers and phoned him.
32. On 8 February, a nurse from the mental health team assessed Mr Brhane. She noted that Mr Brhane struggled with stress and anger issues. He had a history of psychosis compounded by his cannabis misuse. Mr Brhane denied any current thoughts of suicide or self-harm or drug use since being in prison. He refused to be referred to the substance misuse team, Change Grow Live (CGL - a charity organisation that provides support to prisoners with their mental health, relationships, and substance misuse) for any support. He said that he had no concerns on the wing. The nurse noted that Mr Brhane’s mental health appeared stable but referred him to the psychology team for support.
33. On 16 February, a prison mental health nurse assessed Mr Brhane, assisted by his community mental health nurse. Mr Brhane said he was doing well, regularly attended the gym and hoped to get a prison job soon. He said he had spoken to his cousin, who had sent him money. Mr Brhane said he was worried about his immigration status. The nurse said she would contact the Home Office Immigration Enforcement (HOIE) team and ask them for an update. She noted that Mr Brhane was compliant in taking his medication. Mr Brhane told the nurse that he was having bad dreams, but he had had no thoughts of suicide or self-harm and denied any drug misuse. He was being supported by the psychology team. Mr Brhane admitted that he had previously used crack cocaine and agreed to be referred to CGL. The team noted that prior to Mr Brhane’s imprisonment, consideration had been given to him entering a rehabilitation clinic to support his mental health. The nurse therefore referred Mr Brhane to Kent County Council’s adult social care support team, for them to assess his needs. She also sent an email to the Offender Management Unit (OMU) regarding his accommodation on release.
34. On 17 February, staff noted that Mr Brhane was on the waiting list for workshops on coping skills and managing trauma.

35. On 21 February, the Acting Chief Immigration Officer told us that a member of the HOIE team saw Mr Brhane and issued him a Stage One letter. This is a 'Notice of Decision, Decision to Deport' and is the first notice given as part of the deportation process. It asks the detainee to explain to the Home Office why they believe they should be allowed to stay in the UK. This contact and information were not recorded in Mr Brhane's prison records (NOMIS).
36. On 22 February, an officer spoke to Mr Brhane for a key work session. He told the officer that he had wanted to be sent to prison because he thought it would help him control his cannabis addiction and improve his mental health. However, he now regretted his actions as he found being in prison difficult. He had had no contact with his parents and sister, who lived in the Netherlands, since he had arrived in the UK. His cousin had told his family that he was in prison. Mr Brhane raised no other issues.
37. On the same day, the mental health nurse reviewed Mr Brhane. Mr Brhane had been compliant with his medication, denied hearing any voices or feeling paranoid. He said he had nightmares and vivid dreams but denied any thoughts of suicide or self-harm. He said he had received a Stage One letter from the immigration team, to which he had to respond within 20 days. He was worried about his immigration status. She gave Mr Brhane the details of a solicitor that could assist him with legal aid and offered to help him to write his response letter to the immigration team.
38. On 24 February, the mental health nurse saw Mr Brhane and helped him to write his response letter to the Home Office immigration team. When she reviewed Mr Brhane on 27 February, she noted no new concerns. On 1 March, she assessed Mr Brhane, following concerns raised by wing staff about his mental health. She had no concerns about him and noted no evidence of any changes in his mental state or evidence of psychotic symptoms or thought disorder. Mr Brhane said he had a job in the recycling centre and gardens and was enjoying this. She noted that the mental health team would continue to monitor him on a weekly basis.
39. On 6 March, Mr Brhane moved to Medway Wing. At his key worker session, Mr Brhane told an officer that he "felt panicky and stressed" when locked in his cell in the evenings. In contrast, he felt safe when at work, when on the wing and when he was with other prisoners. The officer discussed ways that Mr Brhane could try to improve his mood when locked up. Mr Brhane said he wanted to remain in the UK upon release from prison and did not want to return to Eritrea. He wanted to speak to his offender manager and the officer told him to apply to do this.
40. On 8 March, a psychiatrist assessed Mr Brhane with the mental health nurse. Mr Brhane said he was worried that he would be deported to Eritrea and was getting a solicitor and his cousin to help him with this. The psychiatrist noted that Mr Brhane was anxious in relation to his immigration status, but she had no concerns about him. Mr Brhane was settled in prison, denied having any symptoms of psychosis or plans to harm himself and was compliant with taking his medication. She noted that the mental health team would continue to monitor Mr Brhane's mental state.
41. That night at around 11.00pm, Mr Brhane told staff that he was hearing voices telling him to hang himself. Staff found a noose in his cell. Staff started ACCT procedures and moved him to the Care and Separation Unit (CSU) under constant

supervision until a full assessment could be completed the next day. (The CSU cell is a safer cell with reduced ligature points and a Perspex door.)

42. The next day, Mr Brhane said he no longer wanted to kill himself and the voices had stopped. His main concern was that he did not want to be deported to Eritrea. The staff reassured Mr Brhane that the immigration team had not issued him with a deportation order and that he had already taken the first step in the process in sorting out his immigration status, by responding to the Stage One letter. Mr Brhane's mood improved on hearing this. Staff agreed to invite a representative from the immigration team to attend Mr Brhane's next ACCT review, so that they could provide further information and outline his options for remaining in the UK. Mr Brhane moved back to Medway Wing.
43. On 13 March, prison staff conducted an ACCT case review with Mr Brhane. Staff noted that Mr Brhane's mood was good, he said he no longer heard voices and had no thoughts to harm himself. An immigration team member explained to Mr Brhane that as his conditional release date (CRD) from prison was 16 June, the immigration team would review his immigration status nearer to this time. He already had the right to remain in the UK, however this would be reviewed and may be shortened because of his offence. She emphasised that it was unlikely that Mr Brhane would be returned to Eritrea given the situation there. She confirmed that it was standard procedure for anyone that was a foreign national, who had received a sentence of 12 months or more, to receive the Stage One letter. On hearing this, Mr Brhane felt much better. Staff agreed that ACCT monitoring would be ended.
44. On 20 March, the mental health nurse reviewed Mr Brhane. Mr Brhane said he had received no further updates about his immigration status and had contacted Kent Refugee Action Network services (KRAN), for support. He had provided the OMU with his cousin's home address to support his release, and this was being assessed. On 23 March, Mr Brhane told her that he felt better and less stressed since the immigration team had reassured him that it was unlikely that he would be deported.
45. Mr Brhane continued to have regular key work sessions with an officer during March and April. Mr Brhane told the officer that his cousin's home address had been deemed unsuitable for him to be released to. He hoped that this would not affect his release. The officer suggested that Mr Brhane submitted another release address.
46. During April, the mental health team continued to regularly review and support Mr Brhane with his anxiety about life in the community and being deported. Mr Brhane reported no problems and told staff that the nightmares he had were less frequent. He also attended a trauma workshop. As part of Mr Brhane's Care Programme Approach (CPA - a package of care that is used by secondary mental health services), the staff agreed to invite Mr Brhane's prison offender manager (POM), CGL and KRAN to his next review, on 28 April.
47. On 15 April, Mr Brhane's Incentive and Earned Privilege (IEP) scheme (designed to encourage positive and constructive behaviour) status was upgraded to enhanced in recognition of him being a good and trusted prisoner.

48. On 19 April, a security intelligence report highlighted that on 17 March, Mr Brhane had ordered six boxes of vapes, which was 88 in total. Two days later, on 19 March, he had tried to order a further six boxes, but this was refused. No further information was recorded about whether this matter was investigated any further nor was there any evidence that staff spoke to Mr Brhane about it.
49. On 28 April, the mental health nurse carried out Mr Brhane's review. Other staff were also present. Mr Brhane told staff that he was doing well and enjoyed working in the gardens. He said he was not anxious, was not hearing voices, nor had any thoughts of suicide or self-harm. Mr Brhane said that he had not taken drugs since being in prison but was concerned that he might relapse. He said that he had told the immigration team that he wanted to be deported to the Netherlands, as this was where his family lived. If he was not deported, the OMU agreed to support Mr Brhane to find suitable release accommodation. They also agreed that they would contact the immigration team for an update on this. Staff present also referred him to CGL and the psychiatrist.
50. On 2 May, Mr Brhane failed to attend a coping skills workshop. No reason was noted.
51. On the evening of (Saturday) 6 May, a Custodial Manager (CM) started ACCT procedures after Mr Brhane said that he was hearing voices and felt suicidal. Mr Brhane had made a ligature from torn bedsheets. Mr Brhane told his key worker that he was concerned about his immigration status. The key worker emailed the immigration team and asked them to speak to Mr Brhane. He also contacted the POM. Mr Brhane was happy with the staff's immediate response, which helped to improve his mood. Staff set his ACCT observations at hourly until his ACCT assessment.
52. The next day, an officer completed Mr Brhane's ACCT assessment. Mr Brhane said that he was struggling in prison, although when he was at work, he felt better. Mr Brhane had around five weeks left of his sentence. The officer noted that deportation was not an issue, but he needed support with finding suitable accommodation for when he was released from prison.
53. A Supervising Officer (SO) and other prison staff conducted an ACCT case review. (As it was a Sunday, no mental health staff were on duty to attend.) Mr Brhane said that he had anxiety, sleep problems and was worried about his future. The staff informed Mr Brhane that a full review would take place on Tuesday and staff from HOIE, the mental health team and the OMU would be asked to attend, so that his concerns could be reviewed in greater detail. Staff decided to increase Mr Brhane's observations to twice an hour until his next ACCT review.
54. The ACCT record noted that staff allowed Mr Brhane to work in the gardens as he said that this benefited his mental health. (Prisoners on an ACCT were not normally allowed to work in the gardens at the weekend because this was an unsupervised job. Staff made an exception for Mr Brhane.)
55. On 9 May, a SO and a nurse conducted an ACCT case review. Although invited, HOIE staff were unable to attend. No reason for this was recorded. Mr Brhane told staff that he had no thoughts of suicide or self-harm but felt stressed when he had time to think. Staff said that the immigration team had been asked to visit him as

soon as possible. The POM was also unable to attend the review. However, he had informed Mr Brhane that Mr Brhane's sister had contacted him and had provided some information relating to his possible move to the Netherlands, which he had passed onto the HOIE. The nurse told Mr Brhane that his community support team would continue to support him now and after his release from prison. Staff reduced Mr Brhane's observations to three overnight between 8.00pm – 7.00am, with staff required to have one daily conversation with him. Staff started an ACCT care plan and noted that Mr Brhane's main concern related to his immigration status, noting his release date, 16 June, as a key trigger.

56. On 10 May, an officer noted that when Mr Brhane arrived for work in the gardens, his ACCT document did not travel with him. On 11 May, when Mr Brhane arrived for work in the gardens, his ACCT document again did not travel with him. Later, Mr Brhane told a SO that he had submitted an application for emergency vapes two days earlier and had not received a response. The SO said he would chase this up.
57. On 12 May, a nurse and a member from IMB conducted an ACCT case review. Mr Brhane said he was still anxious when locked in his cell but had no thoughts of suicide or self-harm. The nurse noted Mr Brhane was concerned that he had still not seen the immigration team to discuss his immigration status. Staff told him that a meeting had been arranged in a couple of weeks' time that would include immigration staff, his POM and the nurse. Mr Brhane was happy on hearing this news. The staff agreed that the ACCT could be closed.
58. On 18 May, the immigration team issued an IS91 Reasons for Detention (and bail pack) letter for Mr Brhane. An IS91 is notice of the immigration holding power, where on release a person can still be held in custody, or in an immigration centre. This gave instructions to the prison not to release Mr Brhane on 16 June without contacting the immigration team. A prisoner can apply for bail once they have received an IS91. This information was sent to the OMU, but staff did not tell Mr Brhane at this stage.
59. On 20 May, staff completed the ACCT post closure review. Mr Brhane said that he was still a little stressed when locked in his cell at night, but it was not as bad as it had been. He said working in the gardens helped him, he felt supported and was able to talk to a nurse if he ever needed help.
60. On the same day, the Acting Chief Immigration Officer and a member of the immigration team saw Mr Brhane and gave him the IS91 letter. She told us that she had no concerns about Mr Brhane at the time. Her contact with Mr Brhane was not recorded in NOMIS. She told us that although the immigration team at Maidstone has access to NOMIS, they do not routinely record their contact with prisoners on it.
61. On 23 May, during a key work session, the key worker praised Mr Brhane for several positive reports about his work in the gardens. He told the key worker that he had received the IS91 letter, and this had caused him additional anxiety. The key worker explained that the paperwork did not mean that he would definitely be deported. Mr Brhane said that he maintained contact with his family by phone and felt safe in the prison.
62. On 30 May, staff found Mr Brhane in his cell having a seizure. Healthcare attended, treated Mr Brhane and he recovered. The healthcare team confirmed Mr Brhane

was under the influence of drugs. The security team confiscated a vape found in his cell. Staff issued Mr Brhane with a disciplinary warning and referred him to CGL.

63. That afternoon, a forensic psychiatrist and a mental health nurse assessed Mr Brhane. Other staff were also present. Staff noted that although Mr Brhane had earlier been under the influence, he did not have psychotic symptoms or thoughts of suicide or self-harm. The nurse reported that he had received an email from the immigration team that stated that Mr Brhane had not lost his asylum status, but had been placed on a IS91, which meant that he would remain in prison after his CRD on 16 June. Mr Brhane would therefore be able to apply for immigration bail and they encouraged him to find a solicitor to assist him do this. Immigration staff had noted that Mr Brhane would need to find accommodation that he could be bailed to. The nurse told us that he gave Mr Brhane a copy of the immigration letter. He said that he had been liaising with the immigration team in preparation for Mr Brhane's release so that he knew where he would be released and could ensure community mental health services continued to support him.
64. On 2 June, a prison senior manager conducted a disciplinary hearing about Mr Brhane's suspected recent drug use. Mr Brhane said that he had used another prisoner's vape. He had then got a headache and could not remember what happened to him next. Mr Brhane said he was unaware of what was in the vape and believed it was tobacco. He refused to say who gave him the vape for fear for his own safety. Based on Mr Brhane's admission, the manager dismissed the charges against him.
65. On the evening of 7 June, Mr Brhane told an officer that he was hearing voices again and said he wanted to kill himself. Within five minutes, staff found him with a ligature in his cell. Staff immediately moved Mr Brhane to a safer cell in the CSU, started ACCT procedures and initially placed him under constant observation. Mr Brhane said he felt comfortable being in a cell that had a Perspex door that he could see out of. Staff noted that Mr Brhane was settled in CSU and had been given DVDs to watch. They reduced his ACCT observations to twice an hour overnight.
66. The next morning, a SO chaired an ACCT case review with a mental health nurse and other prison staff. Mr Brhane said that he had found it difficult to cope when locked in his cell at night. However, he had had a good night's sleep and was feeling better. He wanted to be located back in his cell on Medway Wing. CGL and the nurse provided Mr Brhane with some coping method advice and distraction techniques. Mr Brhane told staff that he would ask for support if he was finding it difficult to cope. They noted that he had no acute psychosis symptoms and relocated him back to Medway Wing. The psychiatrist would review him in two weeks' time.
67. Mr Brhane was worried that he did not have a suitable bail address. A SO noted that wing staff would help Mr Brhane to get an immigration lawyer to assist him (there is no further information to confirm whether this did indeed happen). Staff reduced his ACCT observations to hourly between the hours of 5.30pm and 8.00am with one conversation each day. The Head of Safer Prisons agreed that Mr Brhane would be issued an emergency vape pack. The ACCT care plan was not updated.
68. On 9 June, a nurse noted in Mr Brhane's medical record that the immigration team had emailed him, confirming that Mr Brhane had been issued with an IS91R on 20

May and was aware that he would be detained in prison at the end of his sentence. East Kent probation had identified that a property might be available for Mr Brhane to be bailed to for 12 weeks. Mr Brhane had told the immigration team that he wanted to go to the Netherlands. However, they had told him that this would not be facilitated without any proof that he had residency there. They were waiting for Mr Brhane to provide further information and asked again that he be reminded of this so that they could process his release referral paperwork. None of this information was recorded on Mr Brhane's prison records.

Events on Monday 12 June

69. An officer told us that on 12 June at around 8.30am, Mr Brhane went to work. The officer had no concerns about Mr Brhane, noting that he appeared to be in a good mood. Mr Brhane returned to the wing briefly to collect his bail application forms as he wanted help completing them. The key worker also had a conversation with Mr Brhane and reminded him that he had a key worker session scheduled that day. He had no concerns about Mr Brhane. (The key worker session was later cancelled due to staff shortages.)
70. Around 10.00am, a SO chaired an ACCT review with a nurse, another nurse from the mental health team and a representative from CGL. Mr Brhane told staff that he was coping well when locked in his cell and watching television helped. His sleep had also improved. While Mr Brhane raised no concerns, he disclosed that he owed another prisoner, who he described as a friend, two vapes. He said he was not worried about this, and neither was he being pressured to return them. He had applied for emergency vape packs. The SO told us that he was aware that Mr Brhane still had some vapes of his own. Staff noted that Mr Brhane's release date was Friday 16 June and the immigration team had agreed to assist him in completing his bail application. Mr Brhane said that he intended to get a solicitor to represent him at his bail hearing. The team agreed that Mr Brhane's ACCT observations would be reduced to four (random) overnight checks between 8.00pm and 7.00am. His next ACCT review was scheduled for 15 June.
71. Around 12.30pm, staff noted that Mr Brhane's emergency request for vapes had been refused. Mr Brhane's application had stated that he wanted five boxes of vapes because he needed to pay someone back by Monday. His request was referred to the safer custody team to make further enquiries about debt management and the possibility of bullying taking place. Staff submitted a security intelligence report and told senior officers on Medway Wing.
72. After lunch, when Mr Brhane returned to work, an officer helped him to complete his bail application form. Mr Brhane still did not have a release address. He said that he had spoken with a refugee charity and although he was scheduled to have had a meeting with Kent County Council (KCC) about accommodation, they had cancelled this meeting. He said he planned to contact KCC the next day to rearrange the meeting. His community offender manager was looking into sourcing CAS3 accommodation (temporary community accommodation service for homeless prisoners) for Mr Brhane. After completing the form, Mr Brhane returned to work. The officer had no concerns about him.
73. An officer from the HOIE team saw Mr Brhane during the day to obtain some further information about his residency in another country and recorded in the immigration

records database that he was 'fine and had no issues'. There was no record of this in Mr Brhane's prison or ACCT records. The immigration team told us that they were unaware that Mr Brhane was being supported by ACCT procedures at the time.

74. Mr Brhane returned from work to Medway Wing around 4.15pm and soon after collected his dinner. Staff checked and locked prisoners into their cells by 5.15pm and had no concerns about Mr Brhane.

Emergency response

75. An Officer Support Grade (OSG) started his shift at 7.20pm. Day staff gave him a full handover and then waited for him to complete the routine check of all prisoners, before their duty ended. They retained the wing radio, which is shared among staff, intending to give it to the OSG when they finished their shift.
76. The OSG got to Mr Brhane's cell at 7.40pm. He looked through the observation panel and saw Mr Brhane slumped in the far-right hand corner of the cell with a ligature (torn green bed sheet) tied to the cell cupboard and around his neck. He immediately ran to the stairs and shouted for staff assistance telling them there was a prisoner hanging.
77. Two officers responded in seconds, running up the stairs to Mr Brhane's cell. Officer A opened the cell door and the three staff went in. The OSG supported Mr Brhane's weight while Officer A used his anti-ligature knife to cut the ligature. At 7.41pm, Officer B radioed an emergency code blue (used when a prisoner is unconscious or has breathing difficulties). Control room staff immediately requested an ambulance.
78. Mr Brhane was unresponsive and showed no signs of life. The OSG started cardiopulmonary resuscitation (CPR). Staff attached a defibrillator to Mr Brhane.
79. At 7.44pm, a nurse got to Mr Brhane's cell with emergency equipment and took over the management of his care. Further healthcare staff arrived and assisted. At 7.59pm, paramedics arrived and instructed staff to move Mr Brhane onto the landing and continued with CPR. At 8.30pm, they confirmed that Mr Brhane had died.
80. Staff told us that Mr Brhane had made five telephone calls in the week before he died. The calls were made to a friend, his sister and a solicitor. The last phone call was made was on 12 June, the day of his death. Despite several early requests, Maidstone did not provide us with a download of these calls and the recordings were subsequently automatically deleted from the system.

Contact with Mr Brhane's family

81. The prison appointed two officers as family liaison officers. At around 11.00pm, they visited Mr Brhane's cousin's house in Canterbury, but no one was in. They continued to try to contact Mr Brhane's cousin by telephone but were unsuccessful. The next day, a prison governor eventually spoke to Mr Brhane's cousin. He also telephoned Mr Brhane's sister (who lived in the Netherlands) and broke the news of Mr Brhane's death. He visited Mr Brhane's cousin on 15 June. During this visit, a

video call was facilitated, and the staff were also able to speak to Mr Brhane's parents.

82. Maidstone contributed to Mr Brhane's funeral costs in line with national instructions. Mr Brhane's body was repatriated back to Eritrea.

Support for prisoners and staff

83. The prison posted notices informing other prisoners of Mr Brhane'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 his death.
84. After Mr Brhane's death, the staff involved in the incident were given the opportunity to discuss any issues arising and were also offered support by the staff care team.

Post-mortem report

85. The preliminary cause of death recorded that Mr Brhane died from asphyxiation caused hanging by a ligature around his neck.

Findings

Management of ACCT procedures

86. When Mr Brhane arrived at Maidstone in January 2023, he had a number of risk factors for suicide and self-harm: he was a foreign national prisoner, had PTSD, and a history of mental health problems, thoughts of suicide and self-harm and substance misuse. He was supported under ACCT procedures on three occasions, in March, May and from 7 June until he died. On all three occasions, Mr Brhane said that he was hearing voices telling him to kill himself and it was clear that he was stressed that he may be deported.
87. We found that overall, the ACCT procedures were managed reasonably well. Case reviews were held regularly, and the majority were multidisciplinary with a member of healthcare in attendance. Staff offered Mr Brhane good and consistent support and clearly invested time to get to know and support him. This is good practice, and the Governor and Head of Healthcare will want to reflect this to relevant staff.
88. However, we identified some deficiencies. Prison Service Instruction (PSI) 64/2011, Safer Custody, says that at the first case review, a prisoner's most pressing needs in relation to his risk of suicide and self-harm should be identified and a care plan should be completed, giving detailed and time-bound actions aimed at reducing the level of risk posed. When Mr Brhane's ACCT was first opened, the care plan noted that Mr Brhane's immigration status was his main concern. The care plan was not updated on the third occasion that ACCT monitoring started to show that Mr Brhane's main concern now included that he did not have a suitable address to be bailed on his release from prison, should he not be deported. The consequence of this would be that he would have to remain in prison after his release date.
89. Furthermore, although staff from the HOIE team had been invited to earlier case reviews and did not attend, there is no evidence that they were consistently invited. This was particularly important because of Mr Brhane's concerns about his immigration status and his need to find a bail address within two weeks of the ACCT being re-opened.
90. We also noted that while being monitored by ACCT procedures, Mr Brhane left his wing on two occasions and attended his prison job. However, his ACCT document did not travel with him when he left the wing and staff could not update the ACCT. We make the following recommendation:

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

- **staff set specific and meaningful caremap actions, identifying who is responsible for them and reviewing progress at each review;**
- **staff consistently invite the HOIE team to contribute to ACCTs where immigration issues are relevant; and**

- **staff ensure ACCT documents travel with prisoners when they leave the wing.**

Contact with the Home Office Immigration Enforcement team

91. Throughout his time at Maidstone, Mr Brhane's overwhelming risk factor was his concern at being deported and what he perceived as a lack of information about his case. Immigration staff attended one ACCT case review on 13 March. They did not attend or provide direct input to any case reviews after this. Given that immigration issues were understandably one of Mr Brhane's main concerns and affected his suicide risk, immigration staff should have been involved. When staff started ACCT monitoring again on 6 May, they invited the immigration team to attend the next review. However, no one from the immigration team attended and no one recorded why.
92. At the very least, we would have expected the HOIE team to provide a written update about Mr Brhane's immigration status. This was all the more important since none of HOIE's interactions with him were noted in his prison records. Despite Mr Brhane still having concerns about his immigration status, staff stopped ACCT monitoring, without this issue being clearly addressed. The ACCT was then re-opened five days before Mr Brhane's death but, again, immigration staff had no involvement in his ACCT.
93. Except for their attendance at one ACCT review, the immigration team saw Mr Brhane on three occasions, including on the day of his death. However, none of these interactions were recorded in Mr Brhane's prison record or ACCT document. The immigration team told us that their staff have access to prisoners' records (NOMIS) but use their own IT system to record contact with prisoners. They also said that this was the case at the six other prisons in the region that they worked in. Prison and healthcare staff told us that communication and information sharing from the immigration team was inconsistent despite them being in the prison daily. The HOIE told us that they were not aware when Mr Brhane was on an ACCT. Given that HOIE staff see prisoners on their own, it is vital that there are robust systems in place to ensure that crucial information about individual prisoners is shared between prison and Home Office staff at Maidstone.
94. From the evidence we have seen, important letters and information regarding Mr Brhane's future in the UK were given to him with little consideration of the effect on his mental health. Regardless of whether or not a prisoner is on an ACCT, such information needs to be delivered with thought and compassion for the prisoner. As previously stated, we are concerned that this may not solely be an issue for Maidstone but also for the other six prisons in the region. We make the following recommendations:

The Deputy Director of Immigration Prison Teams (North and South) should ensure that HOIE staff:

- **share and record their contact with prisoners (and detainees) in prison records, including ACCT documents;**
- **are involved in the ACCT process, including reviews, if there are concerns about a prisoner's immigration or deportation status, and**

- **consider how information relating to immigration status or possible deportation is delivered to prisoners and whether it might increase the risk of suicide or self-harm.**

The Governor and Deputy Director of Immigration Prison Teams (North and South) should review current processes for the sharing of information between prison and Home Office staff at Maidstone and share their findings with the Ombudsman.

Clinical care

95. The clinical reviewer found that the care Mr Brhane received was of a good standard and was equivalent to that which would have been received in the wider community. She noted that when Mr Brhane's mental health deteriorated, he was promptly seen and assessed by the mental health team who also contributed to the ACCT process.

Debt concerns

96. At his ACCT review, which took place approximately eight hours before his death, Mr Brhane told staff that he owed another prisoner vapes and had submitted an application that requested emergency vape packs to repay this debt. Although Mr Brhane told staff that he was not worried about this matter, the ACCT review panel acknowledged that this problem might have, at the time, put additional pressure on Mr Brhane leading up to his release date.
97. A SO told us that this contributed to the panel deciding that ACCT monitoring would continue, so that it would allow staff to ascertain more details about Mr Brhane's alleged debt and whether it was an issue. We note that in March, Mr Brhane had bought 88 vapes and tried to order more two days later. Although staff submitted a security information report about this, there is no evidence that staff took any action as a result or spoke to Mr Brhane about it. The Governor may wish to note this. However, we found no evidence that Mr Brhane was at risk from others when he died. We accept the decision to continue to monitor the situation under ACCT procedures was appropriate, as well as speaking to senior officers on the wing and referring the matter to safer custody for further investigation. Unfortunately, there was no opportunity for this to take place before Mr Brhane died.

Providing relevant evidence and information for PPO investigations

98. In line with PSI 58/2010, The Prison and Probation Ombudsman, the investigator asked Maidstone for relevant evidence needed to investigate the circumstances of Mr Brhane's death immediately after he died, including a download of his telephone calls. Staff did not download these as required, meaning that the information was lost, and the calls were not available to the investigator. We therefore make the following recommendation:

The Governor should ensure that staff provide all relevant information requested by the Prison and Probation Ombudsman's office, including a prisoner's telephone calls, in line with PSI 58/2010.

Good practice

99. Several staff commented on Mr Brhane's love for working in the gardens. Staff encouraged him to continue his role there and made allowances for him to work there even when it was not usual procedure. After his death, prisoners created a floral garden bed, with Mr Brhane's name written in flowers, as a tribute to him and in recognition of the hard work he had put into the garden.
100. As already noted, the clinical reviewer concluded that Mr Brhane received good mental health support. We note two nurses' efforts to support Mr Brhane in particular. They went beyond what could be expected of a nurse in prison. A mental health nurse helped Mr Brhane respond to the first letter he received from HOIE and another nurse liaised with the immigration team in regard to Mr Brhane's release from prison. They should be commended for their efforts to support Mr Brhane and understand and alleviate his concerns.

Inquest

101. An inquest was concluded on 17 May 2024, that the cause of Mr Brhane's death was from asphyxiation by hanging.
102. The coroner concluded the circumstances of Mr Brhane's death was that he took his own life but his intention in doing so is unclear. Factors relevant to the death but which cannot be concluded to have caused or contributed to the death include: There was failure to address Mr Brhane's accommodation concerns. There was failure by Kent County Council for appointments not being met regarding his care needs assessment. There was a lack of support regarding Mr Brhane's mental health issues, lack of psychiatrist support all of which needed to be more frequent and consistent. ACCTs were closed too quickly without actions being completed. There was a failure to ensure that Mr Brhane understood all the information that was provided to him. His mental health issue deteriorated because the IS9IR form was served to Mr Brhane. The timing of release and prospective of accommodation should have been better. The probation service failed to source accommodation. There was failure at times from immigration to give relevant parties and release date for Mr Brhane. At times there was a failure from all parties to communicate in aspects relating to Mr Brhane.

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