

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Joshua Esberger, at HMP Hull, on 11 January 2021**

**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.

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 Joshua Esberger died in hospital on 11 January 2021 while a prisoner at HMP Hull. He died from pneumonia and hypoxic brain injury following a cardiac arrest. He was 28 years old. I offer my condolences to Mr Esberger's family and friends.

Mr Esberger had been remanded to Hull on 9 November, and from 12 November he began to behave in an unusual manner. I am concerned that staff took far too long to investigate the possible causes of his behaviour, including whether he might have taken an illicit substance or was having a psychotic episode.

When Mr Esberger was rushed into hospital on the afternoon of 14 November, hospital clinicians found that he had plastic cutlery lodged in his aero-digestive tract and had inserted a ballpoint pen through his ear, which had passed into his neck. I have seen no evidence to suggest that staff could have anticipated Mr Esberger's actions, but had they investigated his other behaviours more promptly and thoroughly, the seriousness of his condition might have been recognised earlier along with the need to send him to hospital urgently.

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

**Kimberley Bingham**  
**Acting Prisons and Probation Ombudsman**

**January 2023**

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## Summary

### Events

1. On 9 November 2020, Mr Joshua Esberger was remanded to HMP Hull charged with assault, threatening behaviour, possession of offensive weapon, possession of a class B drug and failing to comply with the requirements of a community order.
2. A nurse completed an initial health assessment. He noted that Mr Esberger had attempted suicide and had self-harmed in the last 12 months, but he had no present thoughts of suicide or self-harm. He also noted that Mr Esberger had a diagnosis of bipolar disorder and a history of substance misuse.
3. In the early hours of 12 November, Mr Esberger began ringing his cell bell and making odd statements. A nurse was called to see him. She noted concerns about his mental health and referred him to the prison's mental health team. Mr Esberger continued to behave oddly through the rest of the morning and early afternoon, but by about 4.00pm, he had settled and was noted to be calmly eating his evening meal. At least one officer speculated that Mr Esberger's earlier behaviour might have been due to him using an illicit substance.
4. Later that evening, Mr Esberger began behaving in an unusual manner again and a smell of faeces was noticed coming from his cell. Mr Esberger was due in court for a remand hearing on the morning of 13 November, but when officers went to collect him, he would not get out of bed or respond to them. The officers noticed blood smeared on the cell floor and walls. A supervising officer (SO) asked the orderly officer to intervene but was told that it was his responsibility to open an ACCT and to deal with the problem.
5. Another SO telephoned to ask for a mental health nurse to check Mr Esberger, but when she went to see him at about 4.00pm, officers told her that he had settled down and was cleaning his cell. The nurse accepted what she was told and did not check Mr Esberger.
6. Mr Esberger's behaviour became more extreme on the morning of 14 November and he was seen crawling naked on his cell floor, making hissing noises. Arrangements were made for him to move to the prison's Wellbeing Unit for enhanced support and he went there at about 2.00pm.
7. Mr Esberger walked unaided to the Wellbeing Unit, although the officers who accompanied him noticed that his breathing was laboured. After being called to check Mr Esberger, a nurse immediately recognised that he was very unwell and she called for an emergency ambulance.
8. At hospital, Mr Esberger had a cardiac arrest and while being treated, plastic cutlery was found in his gullet and windpipe and a ballpoint pen was found lodged in his ear, which had penetrated his neck. Mr Esberger remained on life support in hospital until he died in the early morning of 11 January 2021.

## Findings

9. The supervising officer who found that Mr Esberger had apparently harmed himself had to be reminded by the orderly officer that it was his responsibility to start ACCT procedures.
10. Staff failed to promptly and thoroughly explore whether Mr Esberger had taken an illicit substance or was suffering a psychotic episode. There was also a failure to explore whether Mr Esberger might have smeared faeces in his cell as a dirty protest.
11. The delivery of care for Mr Esberger lacked urgency and co-ordination. Had Mr Esberger been thoroughly reviewed earlier he might have been sent to hospital at an earlier stage.
12. We have seen no evidence from CCTV that Mr Esberger was given any meals on 13 November.

## Recommendations

- The Governor should ensure that all staff understand their responsibility to immediately open an ACCT if they hear or observe anything to suggest a person might be at risk of self-harm or suicide.
- The Governor and the Head of Healthcare should ensure that:
  - prompt and thorough investigations are made when a prisoner is thought to have taken an illicit substance, committed an act of self-harm or started a dirty protest.
  - mental health or general nurses are called to assess concerns about prisoners' health and well-being and,
  - nurses always undertake their own assessment of a prisoners' condition and do not accept an officer's evaluation that the prisoner is apparently well.
- The Governor should ensure that officers record when a prisoner refuses a meal, record the reason for the prisoner's refusal and offer the prisoner a doctor's appointment.

## The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Hull informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
14. The investigator obtained copies of relevant extracts from Mr Esberger's prison and medical records. She watched CCTV footage for the evening of 9 November 2020, for the daytime of 10 November and from 9.00am on 11 November to 1.00pm on 14 November: She was not provided with CCTV for the final hour of Mr Esberger's time on G wing. She also watched Body Worn Camera Footage for Mr Esberger's move from G wing to the Wellbeing Unit. The investigator interviewed 17 members of staff between January and April 2021. All of the interviews were conducted by telephone or video calls due to the COVID-19 pandemic.
15. NHS England commissioned a clinical reviewer to review Mr Esberger's clinical care at the prison. The investigator and clinical reviewer jointly interviewed clinical staff.
16. We informed HM Coroner for Hull and East Riding of Yorkshire of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
17. Our family liaison officer wrote to Mr Esberger's mother to explain the investigation and to ask her if she had any matters she wanted the investigation to consider. Mr Esberger's mother asked the following questions, which we have answered in this report and in separate correspondence:
  - What information did the police give the prison about her son's mental health?
  - Why was she not told that her son was not fit to attend court on 13 November?
  - Why had she not been told sooner that her son had been taken to hospital?
18. We issued our initial report on 19 April 2022. Discipline staff at Hull raised a number of concerns about the criticisms in our report and on two of our recommendations. We have revised our initial report to include further discussion to support some of our criticism. We have removed our criticism and recommendation on family liaison, however we have retained our criticism and recommendation on food refusal.

## Background Information

### HMP Hull

19. HMP Hull is a local prison that holds just under 1,000 men in ten wings. At the time Mr Esberger was at Hull, Healthcare services, including mental health services, were provided by City Healthcare Community Partnerships (CHCP).
20. The prison has a Wellbeing Unit to support prisoners with complex needs, which are difficult to meet in the normal prison environment.
21. During an inspection of healthcare services in November and December 2020, the Care Quality Commission (CQC) identified various concerns which included reduced staffing levels that was impacting on patient care. CQC carried out a follow-up inspection in July 2021 to check if improvements had been made. At this inspection, CQC found further concerns which included ineffective triage of applications for healthcare appointments and urgent need was not always identified and acted upon. CQC found there was a significant backlog of patients requiring mental health assessment and that staffing pressures continued due to staff vacancies. CQC issued a requirement notice for CHCP to explain the action it would be taking to address the deficiencies. At a further follow-up inspection in March 2022, CQC found some improvements in delivery of care, but many concerns remained.
22. In August 2022, CHCP ceased providing healthcare services at HMP Hull and were replaced by Spectrum Community Health.

### HM Inspectorate of Prisons

23. HM Inspectorate of Prisons most recent inspection of HMP Hull was in July 2021. Inspectors found healthcare services were weak and failing in some critical areas. Inspectors noted that they lacked confidence that there was sufficient oversight and governance of partnership working, that there were staffing vacancies across all clinical disciplines and that mental health services were not properly resourced.
24. Inspectors found that interactions between officers and prisoners were generally helpful and courteous and it was evident that the relatively stable and experienced staff group had sound knowledge of prisoners in their care. However, inspectors also noted that on some wings, staff remained remote and disengaged.

### 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 28 February 2021, the IMB noted that the COVID-19 pandemic had had an obvious impact on healthcare services with additional pressure on existing nursing staff to carry out day to day clinical work.

## Previous deaths at HMP Hull

26. Mr Esberger was the 11th prisoner to die at Hull since January 2019. Of the previous deaths, four were self-inflicted, five were from natural causes and one was unascertained.
27. In our investigation into a self-inflicted death at Hull in September 2019, we found that the prison failed to conduct a full mental health assessment. We recommended that the prison's mental health triage process should be monitored and reviewed frequently. The prison accepted our recommendation and said that the mental health triage process would be reviewed and monthly audits would be carried out.
28. In another investigation into the death of a prisoner at Hull in April 2019, we found a failure by healthcare staff to review significant medical symptoms. We recommended that appropriate assessments were completed in a timely manner and that ongoing health needs were met. The prison accepted our recommendation and said that the long term condition Standard Operating Procedure had been reviewed and updated. Templates had also been updated, which was underpinned by NICE guidance.
29. It is disappointing that we are having to raise the same concerns and repeat our recommendations about these issues in this report.

## Assessment, Care in Custody and Teamwork

30. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multidisciplinary case reviews involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

## Food refusal

31. HMP Hull has a safety briefing document on food refusal. The document explains that the prison needs to do all it can to address any issues that might be driving the refusal and states that it is vital that the events are properly recorded. Specific guidance includes that the duty Governor should be informed immediately as soon as staff are aware that a prisoner is refusing food, and the prisoner should be offered a doctor's appointment to assess their mental health capacity.

## Key Events

32. On 9 November 2020, Mr Joshua Esberger was remanded to prison at HMP Hull charged with assault, threatening behaviour, possession of an offensive weapon, possession of a class B drug and failing to comply with the requirements of a community order. This was not Mr Esberger's first time in prison custody.
33. Information included in Mr Esberger's Person Escort Record (a record that is completed when a person is transferred from one custodial setting to another) said that Mr Esberger had self-harm warnings over the past several years and had self-harmed by cutting himself within the last month. The PER also noted that Mr Esberger had shown signs of mental disorder and that he had said he had been diagnosed with psychosis and bipolar disorder.
34. On arrival at Hull, a reception nurse saw Mr Esberger for an initial health assessment. Mr Esberger said that he had attempted suicide and had harmed himself in the last 12 months, but that he had no present thoughts of suicide or self-harm. He said that he had a diagnosis of bipolar disorder, although he was not taking medication. He also said that he had a history of cannabis misuse. His clinical records included references to other illicit drug use, including cocaine. The nurse also noted that Mr Esberger had injured his hand while in police custody.
35. Mr Esberger told a reception officer that he had been remanded into custody for offences from two years before and he had punched the wall at court and injured his hand. He said that he had hit the wall in frustration not because he wanted to harm himself. The officer noted that Mr Esberger seemed well, seemed confident, had asked a lot of questions and gave no cause for concern. Mr Esberger declined the offer to be referred to the prison's substance misuse team and said that he was hopeful of getting bail at his next court appearance on 13 November.
36. Mr Esberger was moved to G wing, where newly arrived prisoners spent their first two weeks in quarantine from the general prison population as part of Prison Service measures during the COVID-19 pandemic.

## 12 November

37. At around 4.00am on 12 November, Mr Esberger began ringing his cell bell. The night officer noted that Mr Esberger was making odd statements. He said that he was an undercover officer with the CIA, that there were explosives over the wing and that there was petrol in his cell and he was going to burn down the prison. The officer also noted that there was a very strong smell of faeces and urine coming from his cell and the officer later noted liquid and small solids outside the cell door.
38. Just after 5.40am, a nurse noted that she had been called to see Mr Esberger as wing officers were concerned that he appeared delusional. She noted that Mr Esberger admitted to having mental health problems, but he would not speak to her about the problems. She noted that she did not have concerns that Mr Esberger was at risk of harming himself, but was concerned about his psychological presentation. She referred him to the prison's mental health team.
39. At around 10.20am, a Supervising Officer (SO), went to G wing after officers rang him to say that they were concerned about Mr Esberger's behaviour. The SO told

the investigator that he went to Mr Esberger's door but Mr Esberger was screaming and shouting abuse and he was unable to calm him down to hold any conversation. The SO made an entry in Mr Esberger's records to say that he had not previously raised any concerns so it was possible he had taken an illicit substance. The SO told the investigator that he spoke to the mental health team and they confirmed that Mr Esberger had already been referred to them for assessment.

40. An officer told the investigator that on 12 November he had spent a lot of time talking to Mr Esberger. He had initially been behaving irrationally by throwing water around his cell, saturating his clothes and bedding and had damaged his television. The officer said that he managed to calm Mr Esberger down by asking him about his family. Once he had calmed, he told Mr Esberger that if he would agree to tidy his cell the staff would give him replacement clothing and bedding and another television. The officer said that by the time he left the wing at 4.00pm, Mr Esberger was calm and was eating his evening meal.
41. An officer on duty that night recorded that from early on in the evening, Mr Esberger began making a lot of noise and was making strange comments. The officer noted that at around 9.00pm, there was a strong smell of faeces and urine coming from the cell and it seemed that Mr Esberger had started a dirty protest (a dirty protest is where a prisoner deliberately smears faecal matter on himself and/or over his cell in protest about his treatment). The officer placed a screen in front of the door to prevent Mr Esberger throwing faecal matter onto the landing.

## 13 November

42. At around 6.40am on 13 November, an SO went to G wing to collect several prisoners, including Mr Esberger who were due to attend court that day. The SO said that when he got to the wing he was told about the developments overnight. He went to Mr Esberger's cell, opened his door and tried to speak to him about his court appearance. The SO said that Mr Esberger was lying in bed and would not speak to him. The SO looked around the cell and noted that there was a small amount of blood on the cell floor and some dried blood smeared on the walls. There was a smell of urine in the cell, but no sign of a dirty protest.
43. The SO telephoned a Custodial Manager (CM), who was the orderly officer (the operational manager in charge of the prison). The SO said that he asked the CM to bring some response officers (officers dressed in protective clothing) and discuss with the duty response nurse the interventions needed for Mr Esberger. The SO went to reception to discharge the prisoners due in court that day and he then went to I and J wing for the staff handover.
44. The CM told the investigator that when the SO contacted him, he asked if it was an emergency situation, but the SO said that it was just that he was busy with other duties. The CM told the SO that he was busy too and that it was the SO's responsibility to deal with the situation.
45. Another SO (the second SO) arrived on G wing for duty on the morning of 13 November. An officer told him that the first SO had asked her to start suicide and self-harm procedures for Mr Esberger (the procedures also known as ACCT). The second SO telephoned the first SO to tell him that it was his responsibility to start ACCT procedures as he was the person who had cause for concern.

46. At 8.10am, the first SO started ACCT procedures noting that he had seen blood in Mr Esberger's cell giving concerns that he had self-harmed. He also noted that Mr Esberger had displayed unusual behaviour and talk. He set Mr Esberger's observations at one an hour.
47. The first SO said that the staff handover meeting and records showed that Mr Esberger had been displaying bizarre behaviour, but it was unclear whether it was drug induced behaviour or behaviour due to mental health issues. The first SO telephoned the CM to ask if Mr Esberger would be moving to the Wellbeing Unit for observation. The CM told him that he could not make that decision and that he (the first SO) should contact the prison's mental health team. He telephoned the mental health team and was told that someone would come to check Mr Esberger later that day.
48. There is no entry in Mr Esberger's medical record further to a nurse's mental health referral for well over 24 hours, but at 12.06pm on 13 November an entry was made that he had been triaged as an urgent referral and was high priority due to the concerns about his presentation.
49. The first SO said that at around 1.30pm, he telephoned a CM who had taken over as orderly officer and then telephoned healthcare staff again in the early afternoon to remind them that Mr Esberger still needed to be seen. The first SO said that at just after 3.30pm, he looked into Mr Esberger's cell and saw that it was clean and that the bedding was folded on the bed. Mr Esberger noticed him and lifted his hand to acknowledge his presence. Around ten minutes later, a mental health nurse came to the wing. The first SO updated the nurse on Mr Esberger's apparent improvement. The first SO said that the nurse asked him if it was worth her while seeing Mr Esberger, but he told her that it was her decision.
50. The nurse told the investigator that on 13 November, the mental health team were short staffed when she received a message to see Mr Esberger. She asked if it was urgent and from what she was told, it did not sound as if the staff were overly worried. She said that she asked colleagues if they had capacity to help, but they were all struggling with their workloads. She said that she had to go to the segregation unit at 4.00pm for an ACCT review, so on her way she called in to G wing and met the first SO. He told her that Mr Esberger was much different to earlier, he had settled and was cleaning his cell door observation panel. She said that the first SO was no longer concerned that Mr Esberger was at risk. The nurse noted in Mr Esberger's clinical record that he had a history of extensive substance misuse and it seemed that his behaviour might be drug induced. She noted that an ACCT had been opened, but that he was considered to be at low risk of suicide. She also noted that he was due to have a formal mental health review on 15 November. The nurse accepted the information that the initial concerns about Mr Esberger were resolved and she did not check him herself.
51. Entries in Mr Esberger's ACCT through the evening and night included references to him rummaging through paperwork and rubbish, looking out of the window and talking to himself.

## Events of 14 November

52. An officer on duty on G wing overnight noted that Mr Esberger slept for part of the night, but at 5.01am, he was awake and “back to talking/arguing with himself”.
53. At 6.35am and 7.20am, the officer made entries in Mr Esberger’s ACCT and recorded that he was crawling naked on his cell floor, speaking to himself, and making hissing noises.
54. In a statement to the duty Governor, another SO (the third SO) wrote that his officers were very concerned about Mr Esberger’s wellbeing and that he went to see him at about 10.00am. Mr Esberger was sitting on his chair; he was naked and was talking to himself. The third SO wrote that Mr Esberger looked clearly unwell. As there were no mental health nurses on duty at Hull, the third SO telephoned a mental health nurse at HMP Humber for a contribution to the ACCT process, while also telling her that it was clear that Mr Esberger was not well enough to engage in the process.
55. At around 10.30am, the third SO discussed with a colleague moving Mr Esberger to the Wellbeing Unit. The investigator was told that there were a lot of prisoners on the Wellbeing Unit so some adjustments were needed and it was agreed for Mr Esberger to be brought to the unit after lunch.
56. Further ACCT entries in the late morning and early afternoon that day referred to Mr Esberger lying on his bed and being offered, but declining lunch. An officer told the investigator that it was difficult to understand what Mr Esberger was saying that morning. He said that Mr Esberger was wheezing and he had blood or pus around his ear.
57. At around 2.00pm, the third SO and a colleague went to Mr Esberger’s cell to escort him to the Wellbeing Unit. They asked Mr Esberger to put on some clean jogging bottoms, a T-shirt and flip-flops, but Mr Esberger seemed to struggle to understand and his breathing was described as shallow and laboured. The investigator was told that it was a five minute walk from G wing to the Wellbeing Unit and Mr Esberger was able to complete the walk without the need to call for a wheelchair.
58. The investigator viewed body-worn camera footage of the visit to Mr Esberger’s cell and of the beginning of the walk to the Wellbeing Unit. Mr Esberger did not appear physically unwell and there were no obvious signs of injury or blood stains on his body. However, staff had to repeat his instructions many times and there was no evidence to suggest that Mr Esberger was deliberately disregarding instructions.
59. Mr Esberger arrived on the Wellbeing Unit at 2.10pm. He was taken for a shower and was noted to have constantly spat phlegm from his chest.
60. At around 2.40pm, an officer went to Mr Esberger’s cell to give him a drink and to speak to him about how he had sustained various injuries that he had to his face, torso and legs. She officer noted that Mr Esberger was bleeding from his ear and his breathing was very laboured. Mr Esberger said that he had had a “funny turn” in his cell and had fallen. He also said that he thought he might have COVID-19.
61. An SO had spoken to a nurse to ask her to check Mr Esberger, and she arrived while an officer was speaking to him. The nurse said that the moment she saw Mr

Esberger she recognised he was very unwell and she told the officers to call an emergency ambulance, which arrived in around ten minutes.

62. After assessing Mr Esberger, the paramedics took him to Hull Royal Infirmary where he arrived at 3.37pm. At hospital, Mr Esberger was found to have a rapid heart rate, low blood oxygen concentration and he was noted to be confused. Mr Esberger then had a cardiac arrest and his heart stopped beating for ten minutes. While being treated, a plastic spoon and fork were found in his upper aero-digestive tract (gullet and windpipe). He also had a ballpoint pen inserted through his right ear, which caused a penetrating injury to his neck. The items were removed and he received treatment for various complications.
63. Mr Esberger remained in hospital and at 6.25am on 11 January 2021, it was confirmed that Mr Esberger had died.

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

64. At around 9.00pm on 14 November, the prison contacted a family liaison officer (FLO) at his home and told him that Mr Esberger had been admitted to hospital and that he was likely to die. The FLO was told that there was no recorded next-of-kin for Mr Esberger, but that the prison would contact Humberside Police for help in identifying the family. (Mr Esberger had in fact given the prison his mother's address and telephone number). The FLO went into the prison and was given a mobile telephone number that had been identified for Mr Esberger's mother. An officer telephoned Mr Esberger's mother at just after 10.00pm to tell her that her son was in hospital and was seriously unwell. Mr Esberger's mother went to the hospital that evening and spoke to hospital staff.
65. The prison contributed to the cost of Mr Esberger's funeral in line with national guidance.

## **Support for prisoners and staff**

66. Following Mr Esberger's death, a prison governor, debriefed the bedwatch officers who had been with Mr Esberger in his final hours. The prison care team also offered support.
67. The prison posted notices informing other prisoners of Mr Esberger's death, and to offer support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Esberger's death.

## **Post-mortem report**

68. The pathologist gave Mr Esberger's cause of death as pneumonia caused by hypoxic brain injury and cardiac arrest.
69. The pathologist said that the sequence leading to Mr Esberger's death was that he sustained a cardiac arrest at hospital, which starved his brain of oxygen resulting in hypoxic brain injury. In turn, this led to him developing pneumonia that ultimately resulted in his death.
70. The pathologist also said that the two likely scenarios leading to Mr Esberger's cardiac arrest were either that it followed from him developing a severe infection from the penetrating injury to his neck or was as a consequence of an upper airway obstruction from the plastic cutlery. The pathologist said that he did not consider it possible from the post-mortem findings alone to differentiate between the two possibilities he had identified. He added that the cardiac arrest might have been due to both problems.
71. No blood samples were taken for toxicological examination when Mr Esberger first arrived at hospital, so we do not know if he had taken any drugs.

## Findings

### Response to Mr Esberger's unusual presentation

72. When Mr Esberger arrived in Hull on 9 November, he told a reception officer that he was frustrated at having been arrested, but he presented as being confident and he said that he was hopeful of being bailed at his court appearance on 13 November.
73. Nothing of note occurred in the next few days, but from around 4.00am on 12 November, Mr Esberger began acting strangely and officers noticed a smell of faeces coming from the cell. A general nurse referred Mr Esberger to the mental health team as she was concerned about his psychological well-being. An appointment was made for Mr Esberger to have a mental health review on 15 November. Mr Esberger appeared to have settled by about 4.00pm and there was some thought that his earlier behaviour had been due to him possibly taking an illicit substance. Mr Esberger again began to behave oddly from around 9.00pm on 12 November and there were thoughts that he might have started a dirty protest, although he made no comments or any reference as to what he might have been protesting about.
74. Prison Service Instruction (PSI) 64-2011 says that a member of staff who sees or observes behaviour which may indicate a risk of self-harm or suicide must open an ACCT. When an SO went to collect Mr Esberger for his court appearance, he deemed Mr Esberger unfit for court and was concerned for his wellbeing. The SO subsequently opened an ACCT, after the CM made it clear to him that it was his responsibility to open the ACCT.
75. At hospital, Mr Esberger was found to have attempted to swallow plastic cutlery, which remained lodged in his aero-digestive tract. He was also found to have inserted a ballpoint pen through his ear, which had penetrated his neck. We do not know when Mr Esberger swallowed the cutlery or inserted the pen. Staff had no reason to believe that he deliberately wanted to harm himself, and in particular to harm himself in such an extreme manner. We are concerned about the lack of ownership and co-ordination in Mr Esberger's care and management. The investigation showed some tension between the SO and the CM on the initial opening of an ACCT and the responsibility for arranging an investigation into whether or not Mr Esberger had started a dirty protest or whether he had harmed himself.
76. We are also concerned that when a nurse visited G wing on the afternoon of 13 November, she accepted an SO's word that Mr Esberger had settled and was cleaning his cell and she did not check him herself. The nurse indicated that she would act differently in future. We acknowledge that the nurse was busy, but she had been specifically called to G wing to check Mr Esberger and we consider that she should have seen Mr Esberger in person and made her own assessment about his well-being and presentation.
77. On reviewing the body-worn video camera footage, the investigator noticed nothing of striking concern, but we note that a nurse recognised immediately that Mr Esberger was unwell. Again, we cannot determine the point in time when the deterioration in Mr Esberger's condition would have been evident to a clinician, but

that underlines how important it was for him to have been properly and promptly reviewed by a clinician inside his cell and assisted by response officers.

78. It is unclear how many times Mr Esberger might have been offered meals which he either declined or refused. From her extensive review of the CCTV recordings as detailed in paragraph 15, the investigator saw no evidence that Mr Esberger was given a meal on 13 November, nor is there a record indicating that he refused or declined any meals that day. If Mr Esberger had swallowed the cutlery by that time, this would account for him not wanting to eat. We acknowledge that it is not routine for prisons to record when a prisoner simply declines a meal, as a prisoner might decline solely because they are not hungry. However, our concern in Mr Esberger's case is whether staff were engaging with him. Had staff explored with him his reason for refusing or declining meals that day, in line with the prison's safety briefing document, this might have prompted them to ask a clinician to come to see him. We consider that this was a missed opportunity for a clinician to review Mr Esberger.
79. We fully acknowledge the efforts made by discipline staff in trying to obtain engagement with mental health staff and we note that there was no-one from the mental health team on duty on 14 November so contact was made with a mental health nurse at another prison. We also note that it was the discipline staff who made the decision to move Mr Esberger to the Wellbeing Unit. However, despite the staff efforts in this regard we remain concerned about the staff engagement with him and whether they could have escalated their concerns with the mental health team or considered other options.
80. We make the following recommendations:

**The Governor should ensure that all staff understand their responsibility to immediately open an ACCT if they hear or observe anything to suggest a person might be at risk of self-harm or suicide.**

**The Governor and the Head of Healthcare should ensure that:**

- **prompt and thorough investigations are made when a prisoner is thought to have taken an illicit substance, committed an act of self-harm or commenced a dirty protest.**
- **mental health and/or general nurses are called to assess concerns about prisoners' health and well-being, and**
- **nurses always undertake their own assessment of a prisoners' condition and do not accept an officer's evaluation that the prisoner is apparently well.**

**The Governor should ensure that officers record when a prisoner refuses a meal, record the reason for the prisoner's refusal and offer the prisoner a doctor's appointment.**

## Clinical care

81. The clinical reviewer concluded that the healthcare Mr Esberger received at Hull was of a mixed standard and was not wholly equivalent to that which he could have expected to receive in the community.
82. The clinical reviewer noted that waiting times at Hull for mental health assessments were lengthy and were not in line with the timescales agreed within the contract for services: in Mr Esberger's case his was an urgent referral so he should have been seen by the mental health team within 48 hours. The clinical reviewer noted that at interview, the nurse said that urgent referrals were being seen in around one week. The clinical reviewer noted the missed opportunity for the nurse to have assessed Mr Esberger on 13 November, and that he was not seen by the mental health team before his emergency admission to hospital.
83. The clinical reviewer has recommended that the Head of Healthcare should review the waiting times for mental health services and should formulate an action plan to ensure waiting times are in line with agreed performance standards. The clinical reviewer has also made a recommendation about delivery of the secondary reception healthcare screen.
84. We share the clinical reviewer's concerns about provision of care at Hull. We note, however, that City Healthcare Community Partnerships ceased to provide services at Hull in August 2022 so we make no separate recommendation of our own.

## Informing Mr Esberger's next-of-kin

85. Prison Rule 22 requires prisons to inform the next of kin immediately if a prisoner becomes seriously ill. Prison Service Instruction (PSI) 64/2011 gives instructions on liaising with families of prisoners who have harmed themselves or have died while in custody.
86. Mr Esberger was taken to hospital by emergency ambulance at 3.22pm on 14 November, but his mother was not informed that her son was in hospital until just after 10.00pm that evening. She was informed by the FLO, who had been called at home to come into the prison to help identify the next-of-kin having been told that there were no details in Mr Esberger's records.
87. Although Mr Esberger had named his mother as his next of kin and gave the prison her address and telephone number on arrival at Hull, these had been recorded in his paper documents that were not available at that time in the evening. The only document available to the FLO was Mr Esberger's electronic NOMIS record and that did not contain next of kin details.

## Inquest

88. At an inquest held on 12 June 2024, an inquest jury concluded that Mr Esberger's death was due to pneumonia caused by hypoxic brain injury following cardiac arrest caused by airway obstruction.

**Prisons &  
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