Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stephen Sleaford, a prisoner at HMP Gartree, on 27 October 2022

A report by the Prisons and Probation Ombudsman

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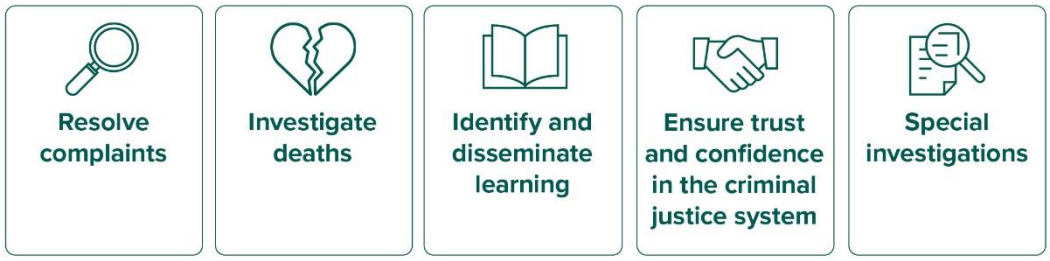
OUR VISION

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

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 His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focussed, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Sleaford died from hanging on 27 October 2022 at HMP Gartree. He was 49 years old. I offer my condolences to Mr Sleaford's family and friends.

Mr Sleaford had been in prison since 2011, and had been in Gartree on several separate occasions over a number of years. It is clear that Mr Sleaford was unsettled in the weeks before his death, but Gartree had begun efforts to transfer him to a different prison and there were no obvious indications that he might take his life.

We have not made any recommendations but have identified areas of learning that the Governor will want to consider.

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 **November 2023**

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Summary

Events

1. Mr Stephen Sleaford had been in prison since 2011 and was serving a 23 year sentence for murder. From May to August 2022, Mr Sleaford moved temporarily to HMP Lincoln for accumulated visits with family and friends, before returning to HMP Gartree on 11 August.

2. On 25 October, Mr Sleaford was thought to be under the influence of drugs and during a cell search, was found in possession of illicit alcohol and was also seen to throw an improvised smoking pipe out of his cell window. At a review the following day of his incentives and earned privileges (IEP) level, his entitlement was reduced to basic, the lowest level. He was noted to be angry at the outcome.

3. At 5.46am on 27 October, at the early morning routine check, the night officer found Mr Sleaford's observation panel covered. The officer gained an oral response from Mr Sleaford and continued with her checks. She did not ask Mr Sleaford to remove the obstruction or otherwise check on his welfare.

4. At 7.07am, a day officer found that Mr Sleaford's observation panel was still covered. The officer tried to get a response from Mr Sleaford, without success. The officer requested support to enter the cell and when staff opened the door, they saw Mr Sleaford on his knees hanging from a ligature tied to the window frame. Staff radioed a medical emergency code and cut the ligature. Staff also radioed for a response from anyone who could do cardiopulmonary resuscitation (CPR), but they did not start CPR until told to do so by a nurse who arrived four minutes later.

5. Paramedics arrived at 7.42am, and took charge of Mr Sleaford's treatment. At 8.01am, they confirmed that Mr Sleaford had died.

Findings

6. While Mr Sleaford was unsettled in the weeks before his death, there were no clear indications that he was at risk of suicide, and he was not subject to additional monitoring when he died.

7. The night officer should have asked Mr Sleaford to remove the obstruction from his observation panel at 5.46am.

8. The officers who found Mr Sleaford hanging should have started CPR without delay.

The Investigation Process

9. HMPPS notified us of Mr Sleaford's death on 27 October 2022. The investigator issued notices to staff and prisoners at HMP Gartree informing them of the investigation and asking anyone with relevant information to contact him. One prisoner responded.

10. The investigator visited Gartree on 15 November 2022 and obtained copies of relevant extracts from Mr Sleaford's prison and medical records.

11. The investigator interviewed eight members of staff and one prisoner at Gartree from 16 to 20 January 2023. He interviewed one other member of staff on 28 February by video link.

12. NHS England commissioned a clinical reviewer to review Mr Sleaford's clinical care at the prison. The investigator and clinical reviewer conducted joint interviews with the clinical staff.

13. We informed HM Coroner for Rutland and North Leicestershire of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

14. The Ombudsman's family liaison officer contacted Mr Sleaford's brother to explain the investigation process and to ask if he had any matters he wanted us to consider. Mr Sleaford's brother asked about his brother's medication. Mr Sleaford's brother also raised some other issues that we have dealt with in separate correspondence.

15. We shared our initial report with Mr Sleaford's brother and with HMPPS. Mr Sleaford's brother pointed out that the clinical review stated that his brother was seen alive at approximately 5.46am on 27 October, but the evidence was that his brother's observation panel was covered so he was not in fact seen. We have amended the clinical review accordingly, and also clarified that the check at 5.46am was the first check on Mr Sleaford since the check at 8.09pm the previous evening. Mr Sleaford's brother also questioned the evidence about his brother's mental health and expressed the view that there were indications that his brother was at risk. In addition, Mr Sleaford's brother asked for a number of comments to be placed on record about Gartree and about the Ombudsman's investigation.

Background Information

HMP Gartree

16. HMP Gartree is near Market Harborough in Leicestershire. It holds up to 700 men mainly sentenced to life imprisonment and other indeterminate sentences. Nottinghamshire NHS Trust provides healthcare. Nursing staff are available 24 hours a day.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Gartree was in January 2023. In his introduction, the Chief Inspector said that Gartree was a well-led institution that continued to provide generally good outcomes for those detained. Inspectors found good leadership from the prison's Governor and Deputy Governor as well as good first-line leadership. Inspectors noted that one search dog had been trained to recognise illegally brewed alcohol and staff estimated that 200 litres were discovered each month.

18. Inspectors noted that the recorded rates of self-harm had reduced by 21% since the previous inspection in 2017. Inspectors noted that many in-cell toilets lacked privacy screening (so were situated in full view of the observation panel). Inspectors found that staff-prisoner relationships were generally good, with 85% of prisoners saying that staff treated them with respect (compared to 64% in similar prisons). Prisoners were also generally positive about the key worker scheme and their assigned key worker.

Independent Monitoring Board

19. 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 November 2022, the IMB noted that it believed that relationships between prisoners and staff were generally positive, with many supportive and constructive interactions observed. The IMB reported a ten percent increase in the number of self-harm incidents compared to the previous year with 27 of the 242 incidents being classed as serious 'near-miss' incidents. The IMB noted that there continued to be an influx of drugs into the prison, although targeted searches allowed detection of various illicit items including drugs and illicitly brewed alcohol.

Previous deaths at HMP Gartree

20. Mr Sleaford was the 16th prisoner to die at Gartree since January 2020. Of the previous deaths, three were self-inflicted and 12 were from natural causes. There was a further self-inflicted death at Gartree on 1 November 2022, but there were no similarities with Mr Sleaford's death.

21. In our previous investigation into the death of a prisoner at Gartree in February 2020, we found that staff failed to take action when a prisoner had blocked his observation panel. In response to our recommendation, the Governor reissued a

notice to staff on the action they should take in such circumstances. We again found an issue with a blocked observation panel in a death in September 2021 (we have not yet released this report).

Incentives and Earned Privileges Scheme

22. The Incentives and Earned Privileges (IEP) Scheme is a Prison Service system used to encourage good behaviour. There are three levels on the scheme: basic, standard and enhanced. Prisoners on the basic level have limited privileges, while prisoners on the enhanced level have greater privileges and are able to apply for the more trusted and more desirable prison jobs, such as wing cleaner. Poor behaviour will usually result in the prisoner moving to a lower level on the scheme and the prisoner will need to display good consistent behaviour to move back to a higher level.

Key Events

23. On 26 September 2011, Mr Stephen Sleaford was remanded to HMP Lincoln charged with murder. This was not his first time in prison. Mr Sleaford was convicted of murder on 24 January 2013 and sentenced to life imprisonment with a minimum term of 23 years.

24. On 23 July 2013, Mr Sleaford was transferred to HMP Gartree before later moving to HMP Lowdham Grange and then to HMP Full Sutton. From June 2018, Mr Sleaford began to receive temporary moves to HMP Lincoln for accumulated visits with his family. (Accumulated visits are where a prisoner saves visits over a period of time to take them all during a brief period of time at a prison close to their family.) Mr Sleaford would not have been able to transfer permanently to Lincoln as it is a local prison, primarily for remand and newly convicted prisoners.

25. On 15 April 2020, Mr Sleaford was transferred back to Gartree.

26. On 6 March 2021, Mr Sleaford rang his cell bell and said that he had tried to hang himself. Staff started Prison Service suicide and self-harm monitoring procedures (known as ACCT). At his first ACCT review later that day, Mr Sleaford said that he had tied a lace around his neck but the lace had snapped and he had fallen to the floor. He said that he had a number of issues, primarily his father's poor health as well as pain he was experiencing from an old leg injury. Mr Sleaford said that he was embarrassed at his actions.

27. Prison staff stopped ACCT procedures on 17 March, when Mr Sleaford was no longer deemed to be at risk.

28. In July, an officer became Mr Sleaford's new key worker. The key worker said that Mr Sleaford could be "fiery", but he believed they established a good working relationship. He said that Mr Sleaford would often complain about Gartree, but would also complain about other prisons, saying that they were worse than Gartree.

29. On 9 March 2022, prison staff searched Mr Sleaford's cell and he was found in possession of fermenting liquid (home-made alcohol, known as hooch). He was also found in possession of some tablets that were not prescribed to him. There is no recorded evidence that staff took any further action.

30. On 25 May, Mr Sleaford moved to Lincoln for a further period of accumulated visits. He returned to Gartree on 11 August.

31. On 23 August, a GP at the prison saw Mr Sleaford about constant dull, throbbing pain in his ankle: Mr Sleaford had been reporting chronic pain in his leg since 2020 and reported an increase in pain from twisting his ankle in June 2021. The GP prescribed a 28 day course of co-codamol to start from 26 August and she stopped his existing prescription of paracetamol. The GP also noted that a physiotherapist needed to review Mr Sleaford.

32. Mr Sleaford's co-codamol prescription ended on 22 September, but after he complained of ongoing pain, an appointment was made for him to attend a clinic on 12 October. For reasons that remain unclear, Mr Sleaford was not seen at the clinic that day.

33. On 26 September, Mr Sleaford asked his key worker about moving to a new prison. He said that he still felt the "presence" of a friend who had died at Gartree the previous year and that he had had a silly argument with some of his friends on his wing. He said that a move to another prison would help him stabilise. Following further conversations with Mr Sleaford, the key worker emailed Mr Sleaford's prisoner offender manager (POM), listing Mr Sleaford's six preferred choices for a prison move, including Lincoln.

34. On 7 October, a Supervising Officer (SO) made a welfare check on Mr Sleaford after he made comments about being frustrated with his leg pain as well as concerns for his father's health and the death of his friend. She noted the various issues that were causing him concern. Among other things, he said that he would turn 50 in February 2023, and he wanted a quieter environment and not one around youngsters. She noted that Mr Sleaford was due to see his POM the following Monday and that while he had "a lot going on", he had no thoughts of suicide or self-harm.

35. On 10 October, the POM met Mr Sleaford about his request to transfer to another prison. Mr Sleaford spoke about the issues that were affecting him, including that his father was in a care home and his health was deteriorating. He also said that his long-term on and off relationship with his partner had ended since his return to Gartree.

36. In an email exchange on 12 October between various staff at Gartree, the POM noted that she understood that Mr Sleaford had completed an application form for a prison transfer, but she had not yet received the form. She added that Mr Sleaford should submit a general transfer application as well as an application to move to Lincoln on compassionate grounds.

37. On the morning of 25 October, a GP at Gartree saw Mr Sleaford after he complained about the pain in his ankle. He said that he had not been able to sleep properly since his prescription for co-codamol had ended. The GP prescribed a five day course of promethazine and noted that Mr Sleaford understood that this was an acute prescription for him to get his sleep "back on track". The GP referred Mr Sleaford for a physiotherapy review.

38. In the afternoon of 25 October, an officer thought that Mr Sleaford appeared to be under the influence of drugs or alcohol. He locked Mr Sleaford in his cell and called for a nurse to come to check him. He recorded various actions in the daily briefing sheet, including placing Mr Sleaford's name on the substance misuse log, so that the substance misuse team would see him. He estimated that it was at least an hour before a nurse came to the wing and, on looking at Mr Sleaford, she said that she did not think he was under the influence of any substances. (Mandatory drug testing was suspended at this time because a restricted regime was implemented at the prison as a result of the COVID-19 pandemic and Mr Sleaford did not meet the prison's current criteria for testing.) Mr Sleaford was let back out of his cell.

39. At around 6.15pm, officers began locking prisoners in their cells for the night. A friend of Mr Sleaford, who lived in the opposite cell, said that he had something to give to Mr Sleaford. An officer unlocked Mr Sleaford's cell and, as he did so, Mr Sleaford threw something out of his window that looked like an improvised smoking pipe. The officer checked outside the cell and found a rolled up piece of foil. He then

searched Mr Sleaford's cell and found two two-litre bottles of fermenting liquid. He placed Mr Sleaford on report.

Events of 26 October

40. On 26 October, a substance misuse practitioner saw Mr Sleaford as a result of the cell search discoveries. Mr Sleaford said that the hooch was for Christmas and he said that he had used Spice (a psychoactive substance) the day before due to the pain in his leg and because he was stressed about his father's health. Mr Sleaford said that he was disappointed that he had let himself down. He said that he needed to "sort himself out", but he declined the offer of support from the substance misuse team.

41. Later that day, a Custodial Manager (CM) saw Mr Sleaford for an IEP review following the discovery of illicit items in his cell the previous day. The CM recorded that in line with policy, possession of fermenting liquid meant that Mr Sleaford would be automatically downgraded from enhanced level to basic level on the IEP scheme. He noted that Mr Sleaford did not react well as he was not expecting to be moved straight to basic level. As he walked from the office Mr Sleaford said "if you want to put me on basic, I will show you basic behaviour".

42. The CM told the investigator that he had known Mr Sleaford for many years. He said that Mr Sleaford was generally a settled prisoner who wanted to get on with his sentence, but that he would flare-up if something irritated him. He said that Mr Sleaford was never physically violent but would vent his anger with words. He said that he thought Mr Sleaford might react by smashing his television or smashing a window.

43. At 8.09pm, Officer A carried out the last routine check of the day. She noted that when she reached Mr Sleaford's cell, they exchanged a joke and they both laughed. She asked him how he was that evening and he said he was all right. She noted that he seemed as cheerful as usual and was getting ready for the night.

Events of 27 October

44. At 5.46am, Officer A carried out an early morning routine check (Mr Sleaford's first check since his check at 8.09pm the previous evening). She said that Mr Sleaford's observation panel was covered, but she tapped the door and Mr Sleaford called out "yo" in acknowledgement. She said that it was common practice for prisoners to cover their observation panels, and in that case, officers were expected to gain an oral response from them.

45. At 7.07am, Officer B went to Mr Sleaford's cell to carry out another routine check and found that the observation panel was obscured. He knocked on Mr Sleaford's door a number of times, but without response. He said that it was common practice at Gartree for prisoners to cover their observation panels although the prison was trying to deal with this problem.

46. At Gartree, the protocol required three officers to be present when unlocking cells during the night patrol state, which was still in place at this time of the morning. (The exception to this would be if the prisoner can be seen, in which case officers are

expected to make a dynamic risk assessment on entering the cell with fewer officers.) As Officer B could not see Mr Sleaford, he went to the wing office around 30 metres away for support. Officer C was in the office and Officer B called the centre office for further support. At 7.13am, staff reached Mr Sleaford's cell. An officer unlocked the door, which Officer B then had to kick open because Mr Sleaford had made a barricade behind the door.

47. Once the door was open, the officers could see Mr Sleaford on his knees hanging from a ligature tied to the window frame. Officer B and Officer D went into the cell, while another two officers radioed a medical emergency code blue (to indicate a prisoner is unconscious or having breathing difficulties). Officer C said that he was unsure if his colleague's call had been acknowledged by the communication room, so he made a follow-up call to be safe. Officer D cut the ligature, and Mr Sleaford fell to the floor. Mr Sleaford was in the corner of the cell against the radiator and Officer C went into the cell to help Officer D move him to where there was more room and they placed him on his back. Officer D said that she could not find a pulse and her only thought was to move Mr Sleaford to his side in the recovery position. She said that she was not first aid trained and she was worried that she could do more harm than good in attempting CPR. She said that she radioed to ask for anyone who knew how to do CPR to come to the cell. (Both Officer B and Officer C were trained in CPR: Officer B acknowledged at interview that he should have started CPR before the nurse arrived. Officer C said that he was about to start CPR when the nurse arrived.)

48. Officer C said that he believed that another officer had said that she thought Mr Sleaford had a weak pulse and he also though he could feel a slight breath from Mr Sleaford which, in retrospect, he thought might instead have been a draft of air coming through the door.

49. A nurse said that she did not hear the code blue call, there was a lot of radio traffic as day staff were registering onto the network. However, a colleague heard the request for someone who could do CPR so they went to the wing and arrived at the cell at 7.17am. A CM arrived at the same time. The nurse said that Mr Sleaford was lying on his side in the recovery position with two officers waiting in the cell. The nurse told the officers that Mr Sleaford needed to be brought out of the cell where there was more room and they needed to start CPR. While the nurse was setting up emergency equipment, Officer C and the CM took turns in giving CPR.

50. The nurse noted that Mr Sleaford had signs of cyanosis in his face (cyanosis is when the skin turns blue through lack of oxygen). She checked Mr Sleaford with a defibrillator a number of times, but each time it advised that no shock could be given and that CPR should continue. Various staff took turns in giving CPR.

51. Ambulance paramedics were called when the code blue call was made and they arrived at 7.42am. The paramedics assisted with efforts to resuscitate Mr Sleaford. At 8.01am, the paramedics declared that further efforts should cease and they confirmed Mr Sleaford had died.

Contact with Mr Sleaford's family

52. A family liaison officer (FLO) was appointed. The FLO and another family liaison officer went to Mr Sleaford's brother's home, where they arrived at 1.30pm and broke the news of Mr Sleaford's death.

53. Gartree contributed to the cost of Mr Sleaford's funeral in line with national instructions.

Support for prisoners and staff

54. One of Gartree's functional Heads debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

55. The prison posted notices informing other prisoners of Mr Sleaford's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Sleaford's death.

Post-mortem report

56. Mr Sleaford's post-mortem report gave his cause of death as hanging by ligature. A toxicology report found a sub-therapeutic level of mirtazapine, an antidepressant (sub-therapeutic means a level below that prescribed to treat an illness effectively). Mr Sleaford was not prescribed mirtazapine.

Findings

Assessment of Mr Sleaford's risk

57. Mr Sleaford was clearly unsettled in the weeks leading up to his death. He was troubled by his father's ill health; he was seeking to move to a quieter environment and a move to a new prison. He was also troubled by on-going pain in his ankle.

58. Mr Sleaford had not long returned from Lincoln following a temporary transfer there for accumulated visits with his family and friends, and he would have been aware that there would be a period of time before he would next be able to return to Lincoln: he would also have been aware that Lincoln was a local prison so he would not be able to move there permanently. However, staff at Gartree had asked Mr Sleaford to identify his preferred prisons for a move and had started efforts to arrange a move for him. He was also seen by a SO on 7 October for a welfare check when he said that he had no thoughts of suicide or self-harm despite the issues that were troubling him at that time.

59. Mr Sleaford had been in prison custody since 2011 and while there were several issues that were causing him concern at the time of his death, we do not believe that prison staff could reasonably have anticipated that he was at immediate risk of either suicide or significant self-harm. Nor do we consider that there was any clear reason for staff to have commenced suicide and self-harm monitoring procedures (ACCT).

Observation panels

60. When Officer A checked Mr Sleaford at 5.46am, she found that his observation panel was obscured. She said that she obtained an oral response from him and indicated to the investigator that that was all that was required of her. The issue of blocked observation panels has come up in two other death investigations at Gartree, and in 2021 we made a recommendation to the Governor to remind staff of the correct procedures.

61. The Governor at Gartree told the investigator that he had circulated the Governor's Notice to Staff setting out the actions they must take if they found a blocked observation panel around five times since he took up the role in 2020, most recently in November 2022. The notice states that if a panel has been blocked, staff should ask the prisoner to remove the obstruction and if the prisoner fails to comply, staff must take immediate action to check on the prisoner's welfare. The notice explains that the cell should be entered in a way that is consistent with local instructions for entering cells and that particular care must be taken during the night state. The notice states that at night, the duty manager must be informed immediately of any blocked observation panel.

62. The notice acknowledges that prisoners might obscure their observation panel to use the toilet or to undress, but they might also do so in order to use drugs or to use an illicit telephone. The notice states that staff must make clear to prisoners the need to keep their observation panel clear and that if a prisoner repeatedly covers his observation panel, he should be managed using the IEP scheme or adjudication process.

63. The notice also states that staff should not accept an oral response alone and staff should always be able to clearly observe prisoners in case they are unwell or there is an emergency situation. The notice stresses that "A clear observation panel can help to save lives".

64. The Governor was certain that staff do know the correct actions to take, and that Officer A was wrong to say that she was unaware. He acknowledged that prisoners at Gartree continue to block their observation panels (mainly because the toilets in their cells directly face the observation panel and are not fitted with privacy screens). However, he said that the prison's daily briefing sheet showed that most staff do contact the duty manager when a prisoner fails to remove the obstruction and obstructions are then removed, and action taken to sanction the prisoner. He said that if staff fail to take the appropriate action, they are spoken to by their line manager.

Governor to Note

65. The issue of blocked observation panels is a persistent one at Gartree and there is historic evidence of systemic failure to address the problem. It is worthy of note that the resident population is predominantly made up of prisoners serving very long sentences and with the obvious challenges that presents in trying to ensure conformity with prison rules. It is also relevant that there are no privacy screens for residents using their toilets. That being said, the observation panels are there for a reason and they should remain unobstructed and staff finding them covered should comply with local policy to mitigate the risk. Systemic failure is exactly the area that the Ombudsman should be making recommendations in. In this case we have noted that the Governor is aware of the issue, has taken several actions to try and change the culture amongst residents and officers and is currently engaged with delivering a re-training program to all of his staff that includes a section on the reasons why complying with the observation panel policy is important. 65% of staff have completed this program and as it is an ongoing effort to solve the problem we will, on this occasion, not make a further recommendation.

66. The actions of Officer A fall below the standard required. It is disappointing that she stated that she was unaware of the correct procedure as she only went through initial training in July 2021, 14 months before this incident. The correct procedure for obtaining a response from the prisoner during roll checks forms part of the syllabus of that training and it is also in the workbooks and forms part of the final exam. The Governor has issued more than one Notice to Staff on the issue and on the balance of probabilities it seems unlikely she was unaware of her responsibilities. Under normal circumstances we would be making a recommendation that discipline procedures were initiated. However, we have noted that she has been spoken to by senior staff and reminded of the correct procedures and that she is due to attend the above mentioned retraining program in July 2023 and, in those circumstances, we will resist making such a recommendation.

Clinical care

67. The clinical reviewer concluded that Mr Sleaford's overall care at Gartree was of a standard equivalent to that which he could have expected to receive in the community.

68. She did, however, identify a number of areas for improvement. In particular, she noted that Mr Sleaford had been reporting chronic pain in his right leg since 2020 and had received medication for this. However, when a four week prescription of co-codamol ended on 22 September 2022, there was no review or alternative plan made to support Mr Sleaford with his chronic pain.

69. The clinical reviewer has made a number of recommendations which we do not repeat in this report, but which the Head of Healthcare will wish to address.

Other learning

70. None of the officers present in Mr Sleaford's cell after he was found hanging began CPR before the nurse arrived. One officer had not received CPR training but both Officer B and Officer C were trained. Discovering someone in these circumstances is clearly shocking for staff and we understand that their ability to make appropriate decisions at speed will sometimes be affected by this. The Governor will wish to consider whether there is anything that can be done to support dynamic decision making (including beginning CPR where the circumstances indicate) in high stress situations.

Inquest

71. An inquest into Mr Sleaford's death concluded on 26 September 2024 that he committed suicide and his cause of death was hanging by ligature.

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