Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul Gobell, a prisoner at HMP Whatton, on 6 November 2021

A report by the Prisons and Probation Ombudsman

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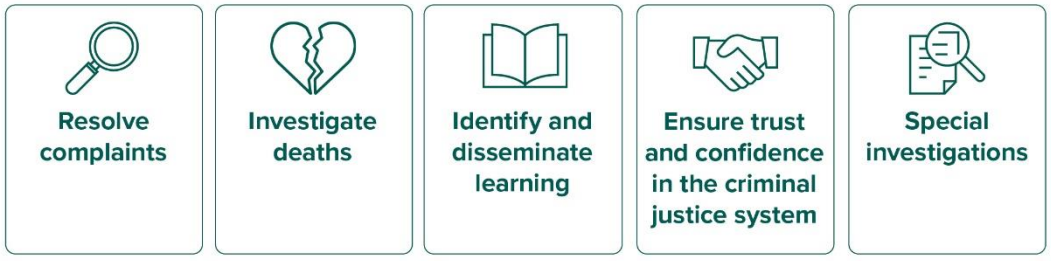
OUR VISION

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

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 Paul Gobell was found hanged in his cell at HMP Whatton on 6 November 2021. He was 59 years old. I offer my condolences to Mr Gobell's family and friends.

Mr Gobell had returned to Whatton on 4 November 2021, after two weeks at an open prison. He had asked to move back and appeared happy with the move. I am satisfied that Mr Gobell gave staff at Whatton no indication that he was at risk of suicide and that they could not have foreseen his actions.

During the morning roll check on 6 November, an officer found that Mr Gobell had covered his observation panel and she could not get a response from him. I am concerned that Whatton does not have a local policy on what staff should do in this situation and this resulted in a delay in entering Mr Gobell's cell. While I am satisfied that this did not affect the outcome for Mr Gobell, it could make a difference in future emergencies.

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

Sue McAllister CB
Prisons and Probation Ombudsman **July 2022**

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Summary

Events

1. In November 2006, Mr Paul Gobell was sentenced to life in prison for rape. In July 2019, he was moved to HMP Whatton.

2. On 20 October 2021, Mr Gobell was moved to HMP Hollesley Bay, a category D open prison. Mr Gobell was at Hollesley Bay for just over two weeks when he told staff that he could not cope in open conditions and wanted to go back to Whatton. Mr Gobell was taken back to Whatton on 4 November.

3. At around 6.50am on 6 November, during the morning roll check, an officer found that Mr Gobell's observation panel was covered. When she could not get a response from Mr Gobell, she contacted the Night Orderly Officer (the officer in charge of the prison at the time) who told her to open the inundation point (a hole in the cell door that a fire hose can be put through) so she could see into the cell. When the officer looked through the inundation point, she saw Mr Gobell hanging.

4. The officer called a medical emergency code and asked the Night Orderly Officer for permission to enter the cell, which was granted. She went in with another officer. They cut Mr Gobell down and laid him on the floor. He was clearly dead as he was stiff and cold so staff did not start CPR.

5. Paramedics arrived at Mr Gobell's cell at 7.31am and confirmed that Mr Gobell had died.

Findings

6. We are satisfied that Mr Gobell gave no indication to staff that he was at risk of suicide or self-harm and that they could not have foreseen his actions.

7. We are concerned that Whatton does not have a local policy on what staff should do when they find a prisoner has covered their observation panel. National instructions say that staff should call the Night Orderly Officer who should deploy staff to the cell. There is nothing in the policy about opening the inundation point. We are also concerned that once the officer saw Mr Gobell hanging, she asked the Night Orderly Officer for permission to enter the cell. This is not necessary where there appears to be an immediate threat to life.

Recommendations

- The Governor should ensure that a local protocol is developed and shared with staff to instruct them on what to do if they find a cell observation panel obscured.

- The Governor should ensure that all prison staff are made aware that where there is an immediate threat to life, they can enter a cell at night without seeking permission from the Night Orderly Officer if it is safe to do so.

- The Governor should ensure that staff receive adequate support following a death in custody.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Whatton and HMP Hollesley Bay informing them of the investigation and asking anyone with relevant information to contact her. Four prisoners responded and the investigator spoke to each of them on the telephone.

9. The investigator obtained copies of relevant extracts from Mr Gobell's prison and medical records.

10. NHS England commissioned an independent clinical reviewer to review Mr Gobell's clinical care at the prison. The clinical reviewer conducted joint interviews with the investigator.

11. We informed HM Coroner for Nottingham City and Nottinghamshire of the investigation. The coroner gave us Mr Gobell's cause of death. We have sent the coroner a copy of this report.

12. The Ombudsman's family liaison officer contacted Mr Gobell's next of kin, his sister, to explain the investigation and to ask if she had any matters she wished the investigation to consider. She asked some questions about how Mr Gobell's move from closed conditions to open conditions was managed which have been answered in separate correspondence.

13. We shared our initial report with HM Prison and Probation Service (HMPPS). They pointed out two minor factual inaccuracies which have been amended in this report. They provided an action plan which is annexed to this report.

14. We sent a copy of our initial report to Mr Gobell's sister. She did not notify us of any factual inaccuracies.

Background Information

HMP Whatton

15. HMP Whatton is a medium security prison in Nottinghamshire which holds up to 801 prisoners convicted of sex offences. Practice Plus Group provides healthcare services. The healthcare centre is open from 7.30am to 6.30pm from Monday to Friday and from 8.30am to 6.30pm on weekends and bank holidays. There is an out-of-hours service at other times. There are no inpatient beds but there is a palliative care suite in the healthcare centre for end-of-life care.

HM Inspectorate of Prisons

16. The most recent full inspection of HMP Whatton was in August 2016. Inspectors reported that Whatton remained an overwhelmingly safe prison. Very good work had been undertaken to improve reception, risk assessment and induction arrangements upon arrival, and there was comparatively little violence or anti-social behaviour. Levels of self-harm had increased in recent times, but overall care for those in crisis was good.

17. HMIP conducted a scrutiny visit to Whatton in August 2020 (in line with its COVID-19 methodology) and reported that managers and staff at Whatton were keeping prisoners relatively safe and motivated during challenging times.

18. Recategorisation processes were being kept up to date. There were 46 category D prisoners in the establishment, of whom about half had been returned from open conditions and had work to do before they could return. Moves to open prisons, other than HMP Haverigg, had been very difficult during lockdown; HMP North Sea Camp had recently offered spaces to enable Whatton prisoners to progress.

19. Even though the establishment was strongly focused on and resourced for interventions, HMIP's survey found that almost a third of prisoners did not know what their custody plan objectives or targets were. Of the 70% who did know their objectives or targets, only 41% said that staff were helping them to achieve them. It was unclear how much of this negative feedback was due to the restricted contact and limited services available during the pandemic.

Independent Monitoring Board

20. 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 May 2021, the IMB found that for over two-thirds of this reporting year, HMP Whatton has been operating in the context of COVID-19. This had meant drastic changes to the operation of the prison. The regime had been severely restricted, with prisoners confined to their cells for most of the day and many activities and functions suspended.

21. The IMB also found that there was a backlog of prisoners waiting to complete the accredited programmes for which they had been transferred to HMP Whatton to undertake. Many prisoners had expressed their concerns about the impact that this

would have on their sentence plan, parole hearings and subsequent release. There continued to be delays in transferring category D prisoners to suitable prisons.

Previous deaths at HMP Whatton

22. Mr Gobell was the 15th prisoner to die at Whatton since November 2019. All the previous deaths were from natural causes. There were no similarities between the circumstances of Mr Gobell's death and previous deaths at the prison.

Key Events

23. In November 2006, Mr Paul Gobell was sentenced to life in prison for rape. In July 2019, he was moved to HMP Whatton.

24. On 24 September 2021, the Parole Board held a review to decide if Mr Gobell could be released from prison on licence. The panel decided that Mr Gobell was not ready to be released from prison but as he had completed all the recommended courses, he met the criteria to be a category D prisoner and could be moved to an open prison. The panel agreed that his release would be reviewed in a year's time. Mr Gobell told his key worker that he was pleased with this and was looking forward to being moved to an open prison.

25. On 20 October, Mr Gobell was moved to HMP Hollesley Bay, a category D prison. When he arrived at Hollesley Bay he was given an induction and the rules and expectations of an open prison were explained to him.

26. On 1 November, Mr Gobell told an officer at Hollesley Bay that he could not cope in open conditions and wanted to move back to Whatton. A prison manager at Hollesley Bay spoke to Mr Gobell and asked if there was anything that they could do to support him. He said that there was nothing they could do and he did not feel comfortable and wanted to go back to Whatton.

27. On 2 November, the prison duty governor held a multi-disciplinary meeting where it was agreed that Mr Gobell could return to Whatton.

28. On 4 November, Mr Gobell returned to Whatton. When he arrived, he had an initial reception health screen with a nurse. The nurse recorded that Mr Gobell did not want to see a GP as he had only left the prison days earlier. Prison staff and healthcare staff also completed a cell share risk assessment (CSRA – used to assess whether a prisoner would pose a risk to a cellmate), where it was documented that Mr Gobell was a low risk prisoner and therefore could share a cell with another prisoner.

29. When prison staff took Mr Gobell to the wing, he said that he was a high-risk prisoner and had never shared a cell with anyone before and was unable to share because he had a medical condition.

30. Prison staff tried to reason with Mr Gobell but the situation escalated which led to Mr Gobell being restrained and located in a cell (on his own).

31. That evening Mr Gobell complained of a pain in his knee. He was taken to hospital where he was diagnosed with a sprained knee. He returned to prison later that evening.

32. On 6 November, at 6.47am, an officer was completing the morning roll check. When she reached Mr Gobell's cell she could not see into the cell because the observation panel was covered. She called Mr Gobell's name but did not get a response. She called the Night Orderly Officer, a Custodial Manager (CM) (who was the manager in charge of the prison at the time), on the radio but did not get a response. She asked an Operational Support Grade (OSG) to go to the office and call the CM on the phone to tell her that she was unable to get a response from Mr

Gobell and that the observation panel was covered. The CM said that the officer should open the inundation point (a hole in the cell door that is used to put a hose into the cell if there is a fire) so that she could look into Mr Gobell's cell. When the officer opened the inundation point, she could see that Mr Gobell was hanging. She immediately called a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties).

33. The officer then radioed the CM to ask for permission to enter the cell, which was granted. At 6.57am, the officer and a second officer entered Mr Gobell's cell. They cut down Mr Gobell and laid him on the cell floor. Mr Gobell was cold and rigid and there were no signs of life. Staff did not start CPR as it was clear that Mr Gobell had rigor mortis (stiffening of the body that occurs two to six hours after death).

34. Paramedics arrived at Mr Gobell's cell at 7.31am and confirmed that Mr Gobell had died.

Contact with Mr Gobell's family

35. At 9.30am on 6 November, the prison appointed an officer to act as family liaison officer (FLO). Mr Gobell's sister was listed as his next of kin so the FLO and a prison manager went to her house to break the news of his death.

36. Mr Gobell's funeral was held on 9 December. In line with national guidance, the prison contributed towards the cost of Mr Gobell's funeral.

Support for prisoners and staff

37. After Mr Gobell's death, a prison manager, debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. When the CM was interviewed, she said that she did not feel that she was supported by the care team and that they had not contacted her.

38. The prison posted notices informing other prisoners of Mr Gobell'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 Gobell's death.

Post-mortem report

39. A pathologist concluded that Mr Gobell had died from hanging.

Findings

Management of Mr Gobell's risk of suicide and self-harm

40. We are satisfied that Mr Gobell gave no indication to staff that he was at risk of suicide or self-harm. He was moved back to Whatton from an open prison at his own request.

41. After Mr Gobell's death, two prisoners told staff that Mr Gobell had previously said that if he returned from open conditions he would kill himself. We are satisfied that staff were unaware of this until after Mr Gobell died. We consider that they could not have foreseen his actions.

42. We reviewed the incident that led to the use of force on Mr Gobell on 4 November. We are satisfied that staff tried to de-escalate the situation and that the use of force was appropriate when Mr Gobell continued to refuse to comply. The correct Control and Restraint techniques were used and Mr Gobell was checked by healthcare staff.

Entering a cell during night state

43. During the morning roll check on 6 November, an officer noticed that Mr Gobell's observation panel was covered. She contacted the Night Orderly Officer, a CM, who told her to open the inundation point so she could see into the cell. It was then that the officer saw Mr Gobell hanging.

44. PSI 24/2011, *Management and Security of Nights*, says that where observation panels are covered, the Night Orderly Officer should be informed immediately, and staff deployed to the cell.

45. We are concerned that Whatton's local night operating instructions do not specify what staff should do if they find that a prisoner has covered their observation panel. An officer contacted the Night Orderly Officer which is in line with PSI 24/2011, but we are concerned that rather than sending staff to the cell, the CM told the officer to open the inundation point to check on Mr Gobell.

46. When interviewed, the CM said that if a prisoner's observation panel was covered, she would always advise the officer to open the inundation point or to go to the outside of the cell and look through the window. The CM said there was not a local policy with instructions on what to do if a prisoner covers his observation panel.

47. Once the officer saw that Mr Gobell was hanging, she called a code blue and asked the CM for permission to enter the cell. PSI 24/2011 says that authority to unlock a cell at night must be given by the Night Orderly Officer and no cell will be opened unless a minimum of two/three (subject to local risk assessment procedures) members of staff are present, one of whom should be the Night Orderly Officer. However, it goes on to say that the preservation of life must take precedence and that where there appears to be an immediate danger to life, cells can be unlocked without the authority of the Night Orderly Officer, where staff consider it safe to enter the cell. We consider that once the officer saw Mr Gobell hanging, she should

have entered the cell and did not need permission from the Night Orderly Officer in those circumstances.

48. We accept that the delay in entering Mr Gobell's cell did not affect the outcome for Mr Gobell, who had clearly been dead for some time when he was found. However, it could make a significant difference in future emergencies. We make the following recommendations:

The Governor should ensure that a local protocol is developed and shared with staff to instruct them on what to do if they find a cell observation panel obscured.

The Governor should ensure that all prison staff are made aware that where there is an immediate threat to life, they can enter a cell at night without seeking permission from the Night Orderly Officer if it is safe to do so.

Staff support

49. The CM said that she had not received any formal support from the care team and that no one had been in contact with her since Mr Gobell's death. We would have expected some formal support to have been offered to her. We therefore make the following recommendation:

The Governor should ensure that staff receive adequate support following a death in custody.

Clinical care

50. The clinical reviewer concluded that the clinical care Mr Gobell received at Whatton was equivalent to that which he could have expected to receive in the community.

Inquest

51. The inquest, held on 18 November 2024, concluded that Mr Gobell died by suicide, to which a failure to respond to an obvious risk of self-harm contributed.

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