

**Investigation into the circumstances surrounding the
death of a man in March 2007, following his absconding
from HMP Hollesley Bay**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

October 2007

Report on the death of a man in March 2007, following his absconding from HMP Hollesley Bay

My Terms of Reference provide authority to investigate, to the extent appropriate, the deaths of those released from custody (either temporarily or permanently) that may raise issues about care provided by the Prison Service. The death of the man, who is the subject of this report is one such case.

The man

The man was born in July 1967. He had a long history of substance misuse and described himself as an “unsuccessful career criminal”. First convicted in 1983, he had been convicted of nearly 80 offences in total. He was no stranger to prison life.

On 9 February 2005, the man was remanded into prison custody at HMP Norwich. On 18 July that year, he was sentenced to five years imprisonment for wounding with intent. A week later he transferred to HMP Peterborough. On 30 September, he was given category C status and transferred to HMP Stocken. Just over two weeks later, he again moved establishments, this time to HMP Blundeston.

In August 2006, the man was given category D status and transferred to HMP Hollesley Bay in Suffolk.

In October 2006, intelligence was received that the man was bullying others. Further information in November indicated he was “pushing boundaries and at times was discourteous to staff”. Intelligence at Hollesley Bay indicated that in December he had become involved in a gang, with the suggestion that he and others were physically intimidating other prisoners.

By January 2007, as part of his resettlement plan, the man had secured work at a hotel. He appeared to have settled down well. He then moved to work at an Oxfam charity shop. He was released on temporary licence to attend both jobs. The temporary licences were appropriately risk assessed and completed in accordance with policy and procedures.

On 7 March, the man was seen with a group of people who were drinking. A conversation was also heard about crack cocaine. A security information report was completed and submitted to the prison’s security department. On 15 March, the man had a positive voluntary drugs test. The test was positive for opiates. He explained that he had brought some co-codamol whilst he was out at work. (Co-codamol is an over the counter medication, used for pain relief. It would produce a positive test result for opiates.)

On 25 March, the man failed to catch his transport into town for work at the Oxfam shop, and therefore arrived late. The shop manager subsequently informed the prison that he had become uninterested in his work and had gone absent without permission the previous day.

That day (25 March 2007), a decision was taken that the man would not be allowed out on any temporary release due to “questionable activities whilst on licence at

Oxfam". This was to allow due consideration of the security risks that he posed, and for thought to be given to how best to support him in meeting his resettlement plan. I think the decision and reasons therefore were entirely appropriate.

Abscond

On 27 March, the man and one other prisoner at Hollesley Bay failed to report for breakfast. Neither prisoner could be found and so a roll check (where the prison counts the number of prisoners) and area search was carried out. Both prisoners concerned were reported as missing. The contingency plans were activated and the man and the other prisoner were officially reported to the local police as having absconded. The actions of staff were fully compliant with the contingency plans.

On 30 March, intelligence was received that the man and the other prisoner had held a third prisoner against his will on 27 March, threatened him with a knife and stolen his watch and bracelet. Other prisoners became aware of this incident and it was then that he and his alleged accomplice absconded. At the time of writing, the other prisoner is still unlawfully at large and the incident is the subject of an ongoing police investigation.

The police contacted Hollesley Bay on 30 March to inform them that the man had been found dead at a friend's flat following an alcohol binge. The attending paramedics were noted to have formed the opinion that, "he had an ulcer and in combination with the large quantity of alcohol consumed, this had ruptured". The man's friend was questioned by the police and there are not thought to be any suspicious circumstances. The friend told the police that the man had told him that he had been released from prison, and that he did not have any reason to think differently.

On 31 March, a search of Hollesley Bay's Bosmere Unit was conducted and a mobile phone was discovered. This phone was found to have been used to contact the absconders. It is believed that during one phone call demands for money were made of the victim of the earlier robbery.

Findings and Conclusion

All these matters were referred to my office and I have conducted a swift and modest investigation.

I judge that HMP Hollesley Bay could not have foreseen that the man would abscond from legal custody, nor his death a few days later. On discovering that two prisoners were missing, the prison acted promptly and appropriately.

In 2006, HMP Hollesley Bay received over 24,000 applications for release on temporary licence. Of this total, some 18,960 applications were approved, and of these all but ten were successful. This gives a successful completion rate of 99.95 per cent against a target of 95 per cent. I believe these figures demonstrate that the risk assessment processes are robust and well considered.

The man's actions in the last couple of weeks of March could not have been predicted. There was no intelligence to lead staff to suspect that he was intending to abscond. I am confident that the actions of managers and staff at Hollesley Bay was appropriate and in accordance with local and national policy. Nor were the circumstances of his death such that they could in any sense have been anticipated by the prison authorities.

I make no recommendations in this case.

Stephen Shaw CBE
Prisons and Probation Ombudsman

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