
A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man at HMP Hewell
in April 2013**

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'*

This is the investigation report into the death of a man, who was found hanging in his cell at HMP Hewell in April 2013. He was 26 years old. I offer my condolences to his family and friends.

A clinical review of the man's medical care in prison was undertaken. The prison cooperated fully with this investigation.

The man was remanded to HMP Gloucester on 26 November 2012. In reception, he reported a history of depression and said that he cut himself when he was stressed. In January 2013, he cut his arm and neck with a razor because he was anxious about a debt outside prison. The prison put him in touch with the Citizens Advice Bureau and he later told staff that he felt better about the situation. On 27 February, he transferred to HMP Hewell. When prisoners were unlocked for lunch in April, an officer found him hanging from a bed sheet attached to the bunk bed in his cell.

After his death, other prisoners said that the man had been distressed about his relationship with his wife and the prospect of his marriage ending. Prison staff were unaware of this and he did not have a personal officer who could have checked whether he had any personal problems. He had not been identified as at risk of suicide and self-harm and his death came as a shock to prison staff.

Despite some confusion over the location of the emergency, I am satisfied that the response when the man was found hanging was timely and appropriate. Prison officers and healthcare staff did all they could but, sadly, he could not be resuscitated. However, I am concerned that staff at Hewell appeared to know little about him and the problems he was facing in his personal life. For prisoners like him, who do not otherwise come to the attention of staff, the personal officer scheme, where officers are required to get to know and act as first point of contact for specific prisoners, might be the only way in which issues and problems are identified. There are, of course, significant pressures on staff in busy local prisons such as Hewell, but there is a need to ensure that all prisoners have an allocated named officer who takes the time to get to know them.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

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SUMMARY

1. The man was born in Lithuania. His mother had died by suicide when he was 15 years old. He had a brother and a sister in the UK and was married. On 26 November 2012, he was charged with two counts of burglary and two counts of actual bodily harm. He told the police surgeon he had a history of self-harm by cutting and depression but did not repeat this to the reception nurse at HMP Gloucester when he was remanded there two days later.
2. In January 2013 at HMP Gloucester, the man made cuts to his forearm and both sides of his neck with a razor. Assessment, Care in Custody and Teamwork (ACCT) procedures were started. ACCT is the Prison Service process for supporting and monitoring prisoners thought to be at risk of harming themselves. He said that he was worried about a debt outside prison and that he sometimes self-harmed when under stress. He was put in contact with the Citizens Advice Bureau (CAB) to help with his debt problem. Two weeks later the ACCT procedures ended when he said he felt better about the situation and was judged no longer to be at risk.
3. The man transferred to HMP Exeter on 11 February 2013 when Gloucester prison closed. At Exeter he asked staff to check with the CAB what was happening with his case as he had not heard anything from them since he moved prisons. He and his co-defendants went to Crown Court on 27 February and were then taken to HMP Hewell.
4. The man lived on Houseblock 3 at Hewell and shared a cell with one of his co-defendants. He did not raise any issues with staff and appeared to get on well with other prisoners. He worked regularly in one of the workshops and helped the foreign national co-ordinator with interpretation for other prisoners.
5. At 11.00am and 11.20am on the day of the incident, the man was observed alive and well in his cell during a roll count to check that all prisoners were present. At about 11.50am, he was found hanging in his cell by an officer unlocking prisoners for lunch. The officer radioed a code blue emergency and began resuscitation. The location was relayed erroneously by the control room and this, and the fact that he was already attending a separate code blue, meant that the emergency response nurse was delayed by about two minutes. We are satisfied that this did not affect the outcome. Paramedics arrived and took over the resuscitation attempt. After several more minutes of treatment, the prison GP pronounced him dead.
6. After his death, several prisoners told staff that the man had been having marital problems. He had been upset but they thought that he had seemed in a better frame of mind during the week that he died.
7. Prison staff knew nothing about the man's family problems and we make a recommendation that the Governor ensures that all prisoners have a personal officer.

THE INVESTIGATION PROCESS

8. The investigator issued notices about the investigation to staff and prisoners at HMP Hewell inviting anyone with information to contact her. No one came forward.
9. The investigator visited Hewell on 1 May and met the Governor and the Deputy Director of Custody. She also met a member of the local POA committee and spoke to the prison's family liaison officer by telephone. She visited the wing and cell where the man had lived and collected copies of his prison record and other relevant paperwork.
10. NHS England (Shropshire and Staffordshire area team) commissioned a clinical reviewer to carry out a clinical review. The investigator and clinical reviewer interviewed seven members of staff. The investigator spoke to another member of staff by telephone. She was also provided with copies of translated transcripts of telephone calls between the man and his wife during the week leading up to his death. She gave verbal and written feedback to the Governor and the prison liaison officer during the investigation about the preliminary findings.
11. One of our family liaison officers informed the man's family about the investigation. They received a copy of the draft report. They raised a number of questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence. The man's sister also provided the investigator with a copy of the blue sheet of a general application form returned to her with the other property in his cell. The application form did not have a number on it and there was no record of it being submitted in the prison general application log book. The report has been amended a result of this information. She said she remained concerned that her brother had not received a full psychological assessment in prison.

HMP HEWELL

12. HMP Hewell was formed in 2008 by amalgamating three separate prisons on the same site (Blakenhurst, Brockhill and Hewell Grange). It now comprises two separate sites – a closed category B prison for adult males (the former Blakenhurst) and an open prison known as The Grange Resettlement Unit (formerly Hewell Grange), also for adult males. The closed site is a local prison and accepts prisoners from courts in the West Midlands, Warwickshire and Worcestershire. It holds up to 1074 men in six houseblocks.

HM Inspectorate of Prisons

13. Her Majesty's Inspectorate of Prisons (HMIP) last inspected Hewell in November 2012. HMIP identified a number of significant concerns about staff morale, poor practice and cleanliness. Too many prisoners in the local prison were sharing cells designed for one.
14. Inspectors found that not all recommendations related to previous deaths at the prison were being addressed. Foreign nationals made up nearly 15% of the population and provision for them was found to be good. Some personal officers had a reasonable knowledge of prisoners but the frequency of staff entries in prisoner case notes was variable and did not meet the requirement of the personal officer policy and reflected a lack of engagement. Management checks on personal officer entries were infrequent and did not address the quality of entries.

Independent Monitoring Board

15. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure that prisoners are treated fairly and decently. The IMB annual report for 2012 noted that self-harm incidents had slightly decreased. Safer custody meetings were considered to be thorough and a new safer custody policy provided clear guidance for staff. The IMB was concerned about the potential impact on Hewell of the announced closure of two nearby prisons.

Previous deaths at Hewell

16. There have been nine deaths at Hewell since 2011. None of these investigations raised issues which are similar to the circumstances of the man's death.

KEY EVENTS

17. The man was born in Lithuania in 1986. He moved to the UK and settled in Hereford with his wife. He worked as a paint sprayer in a factory.
18. On 23 November 2012, the man was arrested and taken to Hereford police station. During his risk assessment interview he said that he suffered from depression but was not taking any medication for it. He said he had cut his wrists a year earlier but had not thought about doing it again. As a result of the risk assessment, he was visited every 30 minutes in his cell.
19. On 26 November, the man was charged with two counts of actual bodily harm and two counts of burglary. He was remanded into custody at HMP Gloucester. His person escort form (PER - a form listing risk indicators that travels with a person every time they move between police custody, the courts and prison) showed two risk markers. The section entitled suicide and self-harm was completed "states he cut his wrists one year ago". The 'health – mental' section was completed, "states he suffers with depression – not medicated (2011)".
20. The man completed his induction at Gloucester including a first reception health screen. He appeared fit and well and said he had no physical or mental health issues. Contrary to the information he had given to the police, he said he had no history of self-harm or depression. The prison GP examined him and from his reported weekly alcohol consumption thought he had borderline alcohol dependency. He did not appear to have any withdrawal symptoms and was not given any medication.
21. On 14 January 2013, the man pressed his cell bell at about 6.00am. The night patrol officer found him bleeding from cuts to his neck and arm and called a code red emergency (the prison emergency code indicating a blood injury). The nurse attended and he told her that he had cut himself at about 2.00am. She washed the cuts and applied steri-strips. The prison GP described the cuts as superficial, but the deepest cut in his right forearm required stitches. Another cut was near his elbow crease and a third on the right side of his neck. He was prescribed medication for three nights to help him sleep. Wing staff opened an ACCT document (prison suicide and self-harm monitoring). He told them that he was worried about debts outside prison.
22. On 22 January, the man told a member of staff during a safer custody support group that he was worried about a £1500 debt outside prison and also that he could be deported back to Lithuania. He said he had received some advice about his debt since the ACCT was opened and felt better about it. He told her that he had self-harmed once before, a few years previously when stressed, but that he was now married and his life was better. The ACCT was closed on 28 January.

23. On 29 January, an officer from Gloucester's offender management unit (OMU) contacted the Citizens Advice Bureau, who sent the man relevant documents about his debts. On 31 January, he told staff that he felt fine since his ACCT had been closed. An officer said he appeared to be in good spirits and reasonably relaxed.
24. On 11 February, the man transferred to HMP Exeter because Gloucester prison was closing. The section on his PER entitled suicide and self-harm was completed "ACCT closed on 28 January 2013". During his first night interview he said he had self-harmed a month previously by making slight cuts to his neck. He said he did not feel at risk of harming himself again. On 24 February, he told an officer about his debt problem and said he had not heard anything from the CAB he was dealing with in Gloucester. She said she would contact OMU for him. (It is not clear whether his debt issues were resolved.) His personal officer wrote on the P-NOMIS (electronic) prison record that he was settling in at Exeter and was "a quiet lad who doesn't ask many questions".
25. On 27 February, the man was convicted of burglary and ABH at Crown Court. He was taken to Hewell, the nearest local prison to the court, the same day. His PER showed three risk markers. The section on self-harm and suicide was completed "ACCT closed 28 January 2013". The section on violence was completed "offences" and the section labelled 'other' was completed "PNC - mental health issues".
26. A nurse completed the man's first reception health screen at Hewell. He did not raise any issues and said he had no thoughts of deliberate self-harm. He was not assessed as a risk of suicide and self-harm. He completed his induction on 28 February. He moved to a cell on Houseblock 3, which he shared with one of his co-defendants. He got a job in one of the prison workshops and his wife visited him on 17 March.
27. The foreign national co-ordinator met the man by chance when he was looking for his cellmate. He subsequently helped interpret a conversation with another Lithuanian prisoner. The officer said on the two or three occasions he met him, he seemed perfectly fine. He said he had good English and appeared to enjoy helping out.
28. The blue part of a general application form dated 3 April (the part retained by the prisoner) was provided to the investigator at draft report stage. The 'your application' section reads, "Can I please see the doctor ASAP as I'm feeling really depressed thank you". There is no record in the prison's general application log book that this form was submitted and it does not have a reference number on it (each application received a reference number when it is received and logged).
29. On 15 April, the man told the prison GP that he had pains in his abdomen that he thought were related to his kidneys and liver. A full blood count and liver function test taken on 17 April were normal and no further action was taken.

30. According to his prison telephone records, the man telephoned his wife's number 274 times while he was at Hewell. The overwhelming majority of these calls are shown as lasting for zero minutes, indicating that he did not get through to talk to her or put the phone down. He last spoke to his wife on Friday 19 April, for just over three minutes, and did not attempt to call her again after that. The investigator was given copies of translated transcripts of calls made on 12, 13, 14, 17 and 19 April. In them he asks his wife to send him money to buy razors and tobacco. He also asks her several times to send in documents relating to his immigration status.

Day of the incident

31. At about 8.25am, the man left Houseblock 3 to go to work. He returned to the wing five minutes later after being told he was not required that day. (The prison over-subscribes the places in the workshops to ensure full attendance. If there are more workers than required, some prisoners have to go back to their houseblock.) An officer locked him back into his cell when he returned. His cellmate, who had gone with him, stayed in the workshop. The officer said he appeared to be his normal self.
32. At 11.00am, a stand fast roll check was called. This is a monthly roll check where all movements in the prison are stopped while officers account for the whereabouts of prisoners. (There are four routine daily roll checks at times when prisoners are in their cells.) A Senior Officer (SO) said that the figures did not tally, so a second stand fast roll check was called at about 11.20am. She swapped the staff about so they counted prisoners in different areas the second time around. This time the roll was agreed. She said she subsequently spoke to the two officers who counted the man in his cell and they told her that he was alive and well when they made their counts.
33. At about 11.35am, Officer A began unlocking the third (uppermost) landing on C spur for lunch at about 11.35am. He unlocked the second landing and then started on the ground floor. He looked through the observation flap of each door before unlocking it. When he got to the man's cell (C1-34), he looked through the observation flap and saw a sheet had been hung up at the window. He said this made the interior of the cell darker and also meant that no one on the upper walkway outside would be able to see into the cell. Prisoners were not allowed to have sheets up at the window. He said he had not known him to put a sheet over his window before.
34. The officer opened the cell door and found that the curtain around the toilet was drawn and the man was facing the wall, hanging from the wooden surround of the top bunk bed. He lifted him up and used his cut down tool which all prison officers carry to cut the noose from the bedframe. He then laid him on the floor and removed the noose, which had been made from a bed sheet. He went out to check the cell number and radioed a code blue emergency and asked for an ambulance. The incident logs show that the officer called the code blue at 11.50am. He began chest compressions to try to resuscitate him. He said he could see no signs of life and thought that he looked dead.

35. The officer said he felt that it was two or three minutes before colleagues joined him. He said there were a number of prisoners outside the cell because those already unlocked had been joined by those coming back from work. One of the prisoners asked the officer if he needed help and he told him to call for staff. Another officer then joined him and they began cardiopulmonary resuscitation (CPR) taking it in turns to do chest compressions. The officer thought this was about five minutes after he had radioed for assistance. (The other officer is on long-term sick leave and so was not interviewed as part of this investigation.)
36. At about 11.45am the orderly officer (the person responsible for managing the day to day running of the prison) that day went to Houseblock 4 in response to a code blue emergency. He had called for an ambulance and was managing that incident when he heard a second code blue for C spur, Houseblock 4. He said he went immediately to C spur but could not see any problem. He radioed the control room and was told that the second code blue was in fact in C spur, Houseblock 3. He radioed his assistant orderly officer and asked him to go to Houseblock 3. The assistant orderly office was unable to do this so he went there himself.
37. The SO was supervising prisoners returning to Houseblock 3 from work. She said she heard a code blue called for Houseblock 4 but did not react because it was not her unit. The prisoners carried on coming back from work and she remembered thinking it could not be a serious incident because movement had not been stopped. She said she then heard a second code blue for Houseblock 4. Soon after, the orderly officer arrived and told her the emergency was on C1, Houseblock 3. Together they went to the man's cell and saw two officers doing chest compressions. The SO made sure the other prisoners on the landing were locked in their cells while the orderly officer took responsibility for managing the incident and directed staff. He radioed the control room and asked them to divert the paramedics responding to the code blue on Houseblock 4 to the cell.
38. Officer B said he was escorting a prisoner to the segregation unit when he heard a code blue call for the emergency response nurse and the Orderly Officer to go to Houseblock 3. Not long after, he heard a second call for all available staff to go to Houseblock 3. He told the investigator that this is "the panic button" so he immediately went there and arrived just before nurses. He offered to help with chest compressions but Officer A said that was not necessary so he began helping to lock up the other prisoners.
39. Nurse A, the emergency response nurse that day was assessing a prisoner on Houseblock 4 in response to a code blue when he said he heard another code blue called for Houseblock 4. He radioed the control room and said, "Hotel 3 (his radio code call sign) be advised on Houseblock 4 dealing with another patient". The control room then told him that the second code blue was actually on Houseblock 3. The nurse assessed the situation and decided the patient he was with was fit enough for him to go to Houseblock 3. He

estimated that the confusion over the location of the code blue caused a delay of one to two minutes.

40. As Nurse A left Houseblock 4, he saw Nurse B carrying the emergency response bag from healthcare. He said he did not know whether Nurse B was on his way to Houseblock 3 or 4 but he took the bag from him and told him to follow him to Houseblock 3. Nurse A said he arrived at about 11.55am and found Officer A doing chest compressions. He took a history from him and began checking the man for signs of life. He attached an automated external defibrillator (AED – a machine which, in certain circumstances, can deliver an electric shock to re-establish a normal heart rhythm). His heart was in asystole (no activity) and a shock was not recommended. There were no signs of life. He inserted an airway while another nurse put a breathing mask on him and administered oxygen. He then took over chest compressions from the officer. Paramedics arrived and the man was moved to the landing to allow more space for the resuscitation effort. Screens were placed around him.
41. Officer B went to collect more screens from the healthcare centre and on the way met the prison GP and asked him to return with him to Houseblock 3. The doctor arrived and saw prison staff and the ambulance crew doing CPR. He said CPR was being done correctly but the man was very blue in colour and had fixed dilated pupils. The defibrillator showed no activity in his heart, so CPR continued. The ambulance crew drilled into his shin bone and injected adrenaline as they could not get access to a vein. When this had no effect, the doctor pronounced him dead at 12.17pm.
42. The incident log completed at the scene by an officer shows that three nurses arrived at the cell at 11.55am and the paramedics at noon. The man was moved on to the landing at 12.05pm with privacy screens in place. A doctor arrived at 12.10pm with officers bringing more screens. The patient report form completed by West Midlands Ambulance Service shows the emergency call for the code blue (on Houseblock 4) was made at 11.48am, they arrived at the prison at 11.53am and at the patient at approximately noon. Their records describe the man as cold to the touch.
43. At 1.00pm, a hot debrief was held for the staff involved in the incident to offer support. At interview most members of staff said they had received appropriate support. The comments of one member of staff were fed back to the Governor during the investigation.
44. All prisoners on open ACCTs had their cases reviewed in case they had been adversely affected by the man's death and needed additional support. During his case review, a prisoner on the man's landing told prison staff that the man had been having relationship difficulties. He said he had a "bad" telephone call on Saturday 20 April and had been withdrawn over the weekend. The prisoner said he had not collected all of his meals over the weekend and had appeared quite low that morning. The prisoner had not told staff about this. The foreign national officer told the investigator that he had spoken to other foreign national prisoners who knew the man. They told him that he had been

upset as a result of conversations with his wife. They had supported him and thought that he was coping. They had not told staff. The prisoners did not wish to talk to the investigator.

Family liaison

45. The Governor, a member of the Chaplaincy and the prison family liaison officer (FLO) drove to the man's wife's home at 4.30pm. They waited for an hour before learning that she worked in a nearby factory and her shift did not finish until 10.00pm. They attempted to find the factory but could not. The FLO then asked the local police to try to make contact with her after 10.30pm. The police later rang to say that she no longer lived at the address they had gone to. The police had spoken to her by telephone and obtained her current address, which they passed to the prison. The next day, the Governor, a member of the Chaplaincy and the FLO visited her.
46. The man's wife said that she was not surprised by her husband's death. She said he had attempted suicide before and had struggled with alcohol and substance misuse since finding his mother dead by suicide when he was 15. She said that she had told her husband that if he did not change his behaviour she would have to leave him.
47. The FLO also contacted the man's brother and sister. The prison offered appropriate financial assistance with the funeral, which was attended by prison staff.

ISSUES

Identification of risk

48. The investigation has found no evidence that the man showed any obvious sign of self-harm or suicidal thoughts while he was at Hewell. He raised no issues with staff, mixed well with his fellow prisoners and regularly went to work. Part of a general application form dated 3 April found in his cell after he died refers to him feeling depressed and asking to see a GP. It does not appear that this form was submitted. The man saw a GP on 15 April after complaining of back pain. There is no indication he said he was depressed. Staff were unaware that he had cut himself and been managed on an ACCT while he was at Gloucester in January. We have not seen a copy of this ACCT document as it is not in his prison record, but it appears that this self-harm was in response to anxiety about debts outside prison. We know from the prison's contact with his family after his death that he continued to owe money. However, we have found no evidence that he raised the issue at Hewell. The clinical reviewer comments in the clinical review:

“There will be times in which previous behaviours or recent medical history have a substantial bearing on how someone needs to be treated in a new prison environment. In this case there is nothing to suggest that knowing beforehand about the previous deliberate self-harming would have changed any interventions at HMP Hewell or altered the outcome.”

49. The man's prison telephone record shows he made many calls to his wife from Hewell. After his death his friends told staff that he had been upset by the conversations with his wife, especially on the weekend before he died. We are satisfied that this is not something that staff could reasonably have been expected to be aware of. Hewell is a busy local prison and prisoners are entitled to use the telephone when on association or when they are unlocked at mealtimes. At such times the officers are supervising the serving of food at the other end of the wing from the telephone. The telephone is not specifically observed and there was no security reason to monitor his calls.
50. However, the man did not have a personal officer at Hewell, so there was no member of staff with whom he was able to build up a relationship and speak to about any family concerns. Personal officers are usually allocated for each half-landing at Hewell so that each officer is responsible for 12 prisoners. Personal officers are required to actively talk to the prisoners they are responsible for, get to know them and make a weekly entry on their prison records. For prisoners like him, who do not otherwise come to the attention of staff, the personal officer scheme might be the only way in which issues such as marital problems or debts outside prison are identified. There was little evidence that any of the staff really knew him or anything about his background and family life.
51. It is not exactly clear why the man did not have a personal officer. A SO remembered at interview that of the two dedicated C spur staff who acted as

personal officers, one was on nights and one was off sick. There did not seem to be a system to cover the absence of personal officers. During the two months the man was at Hewell there was only one entry in his case notes and that said that he was not known to the officer because he had not been allocated to her spur, so was meaningless. There do not appear to have been any management checks that would have identified that he did not have a personal officer which was identified as an issue at the last HMIP inspection. We make the following recommendation:

The Governor should ensure that officers have meaningful contact with every prisoner, through an effective personal officer scheme which ensures that officers get to know prisoners and identify their needs backed up by regular case history notes.

The emergency response

52. The confusion about the location of the code blue appears to have resulted in a delay of some two minutes before the orderly officer and the emergency response nurse reached Houseblock 3. The confusion resulted from the unusual circumstance that another code blue was called on Houseblock 4 only a few minutes before Officer A raised the alarm on Houseblock 3. Although this was particularly unfortunate for the officer, who said at interview that he felt as if it was a long time before help arrived, we do not believe the delay changed the outcome. Neither do we believe that this was a system failure. He acted effectively entered the cell quickly, cut the ligature and began CPR immediately after. Emergency equipment arrived promptly and was in working order. The resuscitation attempt was commendably sustained until the GP pronounced death.

RECOMMENDATION

1. The Governor should ensure that officers have meaningful contact with every prisoner, through an effective personal officer scheme which ensures that officers get to know prisoners and identify their needs backed up by regular case history notes.