A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a prisoner at HMP Hewell who was found dead on 14 February 2014

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 had been on day release from HMP Hewell on 9 February 2014, but did not return. His body was found in a pond in Stoke-on-Trent on 14 February. The cause of his death is unknown. The man was 29 years old. I offer my condolences to the man's family and friends.

The investigation was carried out by a senior investigator. A health professional reviewed the clinical care the man received in prison. Hewell cooperated fully with the investigation.

The man had arrived at Hewell on 7 November 2013 and moved to the open part of the prison, the Grange Rehabilitation Unit, on 23 December. He had been allowed resettlement day release twice before, in January and on 2 February. Because he had got back late to the prison on 2 February, after the police had stopped his car, the prison decided to restrict his travel to the local Redditch area for his next day release on 9 February. He did not return to the prison that day. Five days later, his body was found in a pond on the outskirts of Stoke on Trent.

At the time of writing, the cause of the man's death is unexplained. However, this investigation examined whether there was anything related to the man's management at the prison which might have anticipated or led to his death. I am satisfied that this was not the case. The man had been generally compliant with the terms of his previous day releases from prison and there was nothing to suggest he would not abide by the conditions and return to Hewell after his day release on 9 February. The man's family were unhappy that a planned memorial service at the prison was cancelled without taking their views into account. I understand the chaplain, who took the decision, believed that she was acting in their best interests, but this caused further distress. Sadly, this cannot now be rectified.

The 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 **September 2014**

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SUMMARY

1. On 10 March 2006, the man was convicted of robbery and assault and sentenced to an indeterminate prison sentence for public protection with a minimum period to serve of three years and six months before he could be considered for release. On 3 November 2011, he was released on licence from HMP Sudbury.

2. On 22 February 2012, the man's licence was revoked and he was recalled to prison for breach of his licence conditions. He went to HMP Hewell on 23 February. The man was later held at HMP Leicester and Sudbury again, before he returned to Hewell on 7 November 2013. On 23 December, the man moved to the Grange Rehabilitation Unit, which operates as an open prison on the Hewell site.

3. On 19 January 2014, the man was released on temporary licence for resettlement day release. He returned on time. On 2 February, the man had another resettlement day release. He was required to be back at the prison by 7.00pm, but was over an hour late. The man said that the car he had been a passenger in had been stopped by the police, he had got lost and he did not have a telephone to call the prison. The police verified that they had stopped the car.

4. The prison accepted the man's reasons for his late return. He was allowed a further resettlement day release, but was restricted to the Redditch area. He left the prison at around 9.30am on 9 February and was expected to be back no later than 7.00pm. He did not return. The prison informed the police and five days later, his body was found in a pond on the outskirts of his home town. The cause of his death was still unexplained at the time of this report, almost six months later.

5. The prison had arranged a memorial service on 4 March, the day before the man's funeral. The prison chaplain then decided that a service the evening before the man's funeral would be too stressful for his family and contacted his mother on 3 March to explain this. His family were unhappy about this decision. This appears to have been poorly communicated as the chaplain said she would have gone ahead had she been aware that they still wanted the memorial service at the prison before the funeral.

6. The clinical reviewer considered that the standard of medical care the man received at Hewell was equivalent to that he could have expected to receive in the community. We are satisfied that the decision to allow the man resettlement day release was appropriate and there was nothing the prison could have done to prevent his death. We are concerned that the chaplain did not consult appropriately with the man's family about his memorial service. Unfortunately, this break down in communication cannot now be rectified.

THE INVESTIGATION PROCESS

7. The investigator issued notices at HMP Hewell informing staff and prisoners of the investigation and asking anyone with relevant information to contact him. No one responded.

8. NHS England commissioned a review of the man's clinical care in prison.

9. The investigator visited Hewell on 20 February and met the deputy governor and spoke to staff involved in the man's care. He obtained copies of the man's relevant prison and medical records, and later interviewed staff at Hewell. He gave the prison initial feedback about the preliminary findings of the investigation and followed this up in writing.

10. We notified HM Coroner for Stoke-on-Trent and North Staffordshire of the investigation and have sent a copy of this report to the Coroner.

11. One of the Ombudsman's family liaison officers contacted the man's family to explain the purpose of the investigation and invite them to raise matters they wished the investigation to consider. They had no concerns about the man's care while he was in prison, but were upset that a memorial service for the man, planned for the day before his funeral, was cancelled at short notice. The man's family were otherwise positive about the support they received from the prison's family liaison officer and the deputy governor. The man's family received a copy of the draft report. They did not make any comments.

HMP HEWELL

12. HMP Hewell is an amalgamation of two prisons, the former HMP Blakenhurst, and HMP Hewell Grange. The Blakenhurst site which comprises six houseblocks holds up to 1074 men and is a category B, local prison. The Hewell Grange site continues to operate as a category D open prison and is known as the Grange Rehabilitation Unit, which holds up to 187 men. Health services are provided by Worcestershire Health and Care NHS Trust. Many of the prisoners work in the local community to help them prepare for their release.

HM Inspectorate of Prisons

13. Her Majesty's Inspectorate of Prisons (HMIP) last inspected Hewell in November 2012. Inspectors identified a number of significant concerns about staff morale, poor practice and cleanliness. They noted that too many prisoners in the closed prison shared cells designed for one. Dormitories on the open side were cramped and dilapidated and lacked privacy. The two annexes on the open site provided much better accommodation.

14. Not all Prisons and Probation Ombudsman recommendations following previous deaths at Hewell (which were at the closed site) had been implemented. Some personal officers had a reasonable knowledge of prisoners, but the frequency of staff entries in prisoners' case notes varied. Inspectors found that the range of health services to be generally good. Prisoners were able to see a GP at daily clinics but on the closed site there was a wait of up to12 days for routine appointments. Prisoners at the open site were usually seen within 48 hours. Mental health and pharmacy services were assessed as satisfactory.

15. Prisoners on the open side were fully occupied and had a good range of vocational training. Release on temporary licence (ROTL) was used for a good variety of activities. Inspectors found that there was a comprehensive resettlement strategy to help prisoners reintegrate into the community and there was a structured approach to provide indeterminate sentence prisoners with opportunities to progress to release through periods of temporary release. The prison worked with a range of voluntary sector providers and also offered a range of services to ensure prisoners had training opportunities, somewhere to work and live and had support for health and substances misuse issues after release.

Independent Monitoring Board

16. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community to help ensure that prisoners are treated fairly and decently. The most recently published Hewell IMB annual report, for 2013, noted that resettlement services had continued to improve. The IMB also noted that after a prisoner absconded from the Grange Rehabilitation Unit in October 2013, there was an immediate review of all prisoners and their suitability for release on temporary licence. A lessons-

learnt exercise took place and the deputy governor attended a Multi-Agency Public Protection Arrangements (MAPPA) meeting to discuss the management of the individual and to implement and share a number of learning points.

Previous deaths at Hewell

17. We have investigated seven deaths since 2012 at Hewell. The man's was the only death of a prisoner located at the Grange Rehabilitation Unit. None of these other investigations raised any issues directly relevant to the man's death.

Release on temporary licence

18. There are four types of temporary licence:

- Resettlement day release is to allow prisoners to engage in reparative community work/unpaid employment, life and work skills training/education, maintaining family ties, probation Interviews, etc.
- Resettlement overnight release is to allow prisoners to spend time at their release address, or an approved temporary hostel address, re-establishing links with family and the local community.
- Childcare resettlement for prisoners who have sole caring responsibility for a child under 16 years of age.
- Special purpose is a short duration temporary release, often at short notice, that allows eligible prisoners to respond to exceptional, personal circumstances and to wider criminal justice needs.

Prisoners apply for release on temporary licence under Prison Rule 9 and YOI Rule 5. All eligible applications should be assessed individually in the full knowledge of all the circumstances of the prisoner's offence and offending behaviour.

KEY EVENTS

19. On 10 March 2006, the man was sentenced at Crown Court to an indeterminate prison sentence for public protection for robbery and assault. He had to serve a minimum period of three years and six months before he could be considered for release. The man was held at a number of prisons before being released on licence from HMP Sudbury on 3 November 2011.

20. As part of his licence conditions, the man had to live at an approved premises and was required to address his alcohol, anger and drug problems. On 22 February 2012, the man's licence was revoked after he failed a drug test by testing positive for drugs including ecstasy, amphetamines, cannabis and benzodiazepines. He had previously tested positive for alcohol on a number of occasions. The man returned to prison, HMP Hewell, on 23 February.

21. On 25 January 2013, the Parole Board recommended that the man should move to category D (open) conditions. The Parole Board was satisfied that the man would benefit from further time in open conditions and this outweighed the risk he presented to the public. There was no evidence to suggest that he would abscond. On 27 February, the Parole Board's recommendation was accepted.

22. On 27 March, the man moved to Sudbury. On 11 October, Staffordshire Police received information that the man might have been involved in an incident of domestic violence incident while he had been on day release from the prison. On 26 October, the man was moved back to closed conditions at HMP Leicester while the police investigated. After a police investigation, no action was taken against the man. He moved to HMP Hewell on 7 November.

23. At his health screen when he arrived at Hewell, the man said that he was not currently on any medication, but had an old injury to his left arm. He said he had no thoughts of suicide or self-harm. On 15 November, while working as an orderly (a trusted role helping staff) in the medical unit, the man told a primary care support worker that he had family and legal problems. She recorded that he had no thoughts of suicide or self-harm, but felt low in mood and had trouble sleeping. He also reported panic attacks. She referred the man to the mental health team and the prison doctor, and told the chaplaincy about a family illness.

24. On 21 November, the man saw a Nurse Bfter he injured his back weightlifting and referred him to the prison doctor. The doctor prescribed diclofenac sodium and paracetamol tablets. When interviewed, the nurse described the man as friendly and pleasant and she had no concerns about his mental well-being. On the same day, the primary care support worker told the nurse that the man did not appear to have any physical problems while conducting his orderly duties.

25. On 22 November, it was recorded the man chose not to attend a mental health clinic appointment, arranged after the primary care support worker's referral on 15 November. The next day, a physiotherapist assessed the man's back injury,

gave him some exercises to help to ease the pain and arranged a GP review the following week. On 25 November, the man's medical record indicates he "walked out" of an appointment at the mental health clinic.

26. On the morning of 27 November, as the man had not attended two mental health appointments, a mental health nurse went to see him. The man said that he did not need any support from the mental health team but still had back pain. The mental health nurse conducted a mini mental state examination (MMSE or Folstein test, a brief 30-point questionnaire test that is used to screen for cognitive impairment). He concluded there was no evidence that the man had any thoughts of suicide or self-harm and there was no evidence of aggression or agitation.

27. Later that morning, a prison doctor reviewed the man's back injury. They prescribed tramadol (a synthetic opiate painkiller) 100mgs one tablet twice daily which the man had to collect from the medication hatch. They said that they did not think that the man was deliberately seeking medication but had genuine pain. The man did not mention any concerns about insomnia or panic attacks during this consultation.

28. On 23 December 2013, the man moved to the Grange Rehabilitation Unit, the open prison site at Hewell. On 31 December, a nurse saw the man after he injured his foot playing football. He was given ibuprofen and paracetamol. The man said he was having trouble sleeping and the nurse placed him on the list to see the GP.

29. On 6 January 2014, the man's offender manager (probation officer) in the community emailed Hewell, to say that she was happy for the man to go on town visits as long as he did not contact three named individuals without her prior permission. This was to safeguard them.

30. The man did not attend three clinic appointments to discuss his foot injury in January. No reasons were entered in his medical record.

31. On 8 January, a support worker from the Integrated Substance Misuse Service (ISMS) interviewed the man in relation to him continuing a drug monitoring programme that he had started at Sudbury. The man attended the ISMS harm minimisation support group on 10 January which gives new residents the opportunity to discuss issues about substances misuse in open conditions and introduces the prisoner to 'peer supporters'. The ISMS support worker explained that the peer supporters will usually report concerns about other prisoners to her or her colleagues.

32. On 12 January, Officer A introduced himself to the man as his new personal officer. (Each prisoner is allocated a personal officer. Personal officers should get to know the prisoners they are responsible for, act as a first point of contact for any problems and help with resettlement issues.) Officer A recorded in the man's prison record that he had "no concerns or issues at this time".

33. On 13 January, the prison doctor recorded that the man had reported having a phobia of cows and had requested a medical note to excuse him from farming duties that involved cows. The prison doctor discussed this with a nurse who had seen a scar on the man's body that corroborated his account that he had been attacked by a cow as a child. The doctor issued the appropriate exception certificate.

34. On 14 January, the man saw a Nurse B. Nurse B told the investigator that, when the GP list appears to be getting too long, the primary care nurses offer to see patients who they think they can manage. The man told her that he had suffered from insomnia all his life and had used cannabis and medication to help him sleep. Nurse B gave him detailed self-help advice and a leaflet. Nurse B said at interview that she had not asked the man the reasons for his insomnia.

35. On 14 January, a release on temporary licence risk board recommended the man should be allowed to start unescorted resettlement day release. The board recommended allowing him to leave the prison for six hours. The deputy governor reviewed the board's recommendation on 15 January and decided to approve a release period of three hours, from 9.30am to 12.30pm. The deputy governor told the investigator that she had no direct dealings with the man while he was at Hewell, but decided to restrict the hours to test that he would comply with his conditions before he was allowed to spend longer periods outside the prison.

36. On 19 January, the man was released for three hours of resettlement day release. Officer C wrote that the man returned early. Officer C noted that this was to his credit as his licence had incorrectly stated that he could be out until 7.00pm.

37. On 23 January, the deputy governor agreed that the man should be allowed resettlement day release for the whole day. The same day, the man saw the ISMS support worker and set out his goals for while he was in the Grange Rehabilitation Unit. He disclosed that his main substance issues were alcohol and cannabis. His goals were:

    - To re-integrate back into the community by starting town and home leave.
    - To address motivation, relapse prevention and coping strategies to remain substance free. He stated that his main coping strategy was to eventually gain access to his daughter. He said he had a supportive family and enjoyed both work on the farm and going to the gym.
    - To gain his driving license

38. At interview, the ISMS support worker said she had no concerns about the man. She had attended the man's risk board where no concerns had been raised and she also said no other prisoners had raised concerns about him.

39. On 27 January, Officer A wrote: "[the man] has no issues or concerns at this time and recent positive comments are a credit to him. Still not convinced that

he can stay away from trouble but he has certainly made a good start. Time will tell". When interviewed, Officer A said that the man mixed with others who he thought were involved with drugs, but he did not think that the man was having problems with drugs at that time. He said that the man was level headed, always perfectly pleasant and hard working.

40. On 2 February, the man returned an hour late from his resettlement day release. He told Officer D that the police had stopped the car he had been in for 30 minutes. His satellite navigation system had stopped working and he could not contact the prison as he had no telephone and his friend did not have any credit on hers. Officer D wrote that release on temporary licence would be suspended until the risk board decided what action to take.

41. On 4 February, Officer E recorded that she had seen the man about his late return from resettlement day release. He had been upset about what had happened and was concerned about the impact on his eventual release. The risk board recommended that the man should be allowed resettlement day release to Redditch, which would be reviewed on 11 February.

42. The chair of the risk board told the investigator that they gave the man the benefit of the doubt because the police had confirmed his account. However, the board considered that he should be restricted to the Redditch area while they built a relationship of trust. The chair said that the man's next step would be sourcing community work and then overnight stays at an approved premises. The chair said that the risk board rejected applications for temporary release if they did not think a prisoner was ready to leave the prison.

43. On 6 February, the deputy governor agreed the risk board's recommendation. The deputy governor said that the man had written a letter explaining what had happened and he had realised that he had "pushed the boundaries" and that there could be consequences. She said there was nothing to suggest that he would not comply with his licence conditions or that he might not return to the prison.

44. At around 9.30am on 9 February, the man left the prison for resettlement day release. He was required to be back at the prison by 7.00pm, but did not turn up. Supervising Officer F contacted the police to report the man as failing to return from temporary release. The police visited Hewell at around 9.50pm. They later visited the man's family, but were unable to locate him.

45. At around 4.00pm on 14 February, the police informed Hewell that the man had been found dead, face down in a pond in an area of Stoke-on-Trent. He had been identified by his tattoos and his prison identification card. There is no information about what happened after the man left Hewell on 9 February and him being discovered dead on 14 February.

Contact with the man's family

46. The police informed the man's mother of his death. The Governor and the prison's family liaison officer visited the man's mother at her home on 20

February to offer condolences. The prison family liaison officer maintained contact with the man's family. In line with national policy, the prison offered financial assistance towards the cost of the man's funeral, which took place on 5 March 2014. A memorial service at the prison had originally been arranged for the evening of 4 March but the chaplain cancelled this on 3 March as she believed it would be too stressful for his family, the evening before his funeral. She did not discuss this with his family in advance.

Support for staff and prisoners

47. Notices were issued to staff and prisoners informing them of the man's death. Officers and members of the chaplaincy were available to support prisoners. Those who were identified as at risk of suicide and self-harm monitoring were reviewed in case they had been adversely affected by the news of the man's death.

Post-mortem report

48. At the time of writing, the cause of the man's death was still unknown. A post-mortem examination found no obvious cause of death and a toxicology report is awaited. The post-mortem report received on 18 August 2014 gave cause of death as hypothermia.

ISSUES

Medical care

49. A clinical reviewer concluded that the man's care was equivalent to that which he could have expected to receive in the community, but made some recommendations about health services at Hewell which the Head of Healthcare will need to address. These include the management of insomnia and the recording of medical appointments and other information (such as the reason for non-attendance for appointments) on the electronic medical record.

50. The clinical reviewer concluded that the man had a history of substance misuse but no other significant history of mental or physical issues. A mental health Nurse Bssesed the man and found no evidence that he intended to harm himself. The man attended the harm minimisation programme and seemed fully motivated to maintain positive lifestyle changes in readiness for his return back to the community. He was considered safe to be released on temporary license to prepare for his potential release.

Resettlement day release

51. On 19 January, the man left the prison for his first period of resettlement day release from Hewell. He returned to the prison early. He was granted a further resettlement day release for 2 February, but came back an hour late. The prison accepted the man's reasons for his lateness, and granted a further resettlement day release for 9 February, but this time limited it to the Redditch area to ensure he returned on time and to give him the opportunity to prove he could comply.

52. Prison Service Order 6300 provides guidance on release on temporary licence including resettlement day release. It is made very clear that consideration should be given to behaviour while in prison custody, the risk to the public, risk of further reoffending, failure to comply with licence conditions and the propensity to abscond. There was no intelligence to suggest that, while at Hewell, the man would not return to the prison after he was temporarily released.

53. Staff interviewed as part of this investigation said that the man gave no indication that he might not return to Hewell on 9 February. There was no intelligence to suggest he had any problems with other prisoners or that he had planned to abscond. He had engaged with the drug support team and appeared to be looking forward towards the future and his release from custody. We are satisfied that the decisions to allow temporary release from prison were appropriately considered.

Liaison with the man's family

54. Hewell had agreed to hold a short memorial service at the prison on 4 March, the day before the man's funeral. The man's family wanted the service to be held before the funeral, but, on 3 March, they received a telephone call from a

prison chaplain who informed them that she had cancelled the service at the prison as she thought that it would be too much for the man's family so close to his funeral. The man's mother was upset about this and the man's family decided that they did not want any further contact with the chaplain.

55. In a statement for the investigator, the chaplain said that she had been concerned that a service on the evening before the man's funeral would put his family under a lot of stress and cause further distress. She had contacted the man's mother to explain her view. The chaplain said the man's mother did not tell her that she still wanted the memorial service at the prison to take place before the funeral and the chaplain said that, had she known, she would have held the service as planned.

56. It is regrettable that the chaplain appears to have cancelled the memorial service without proper consultation and seems to have mishandled this communication with the man's family at a very difficult time for them. This is not a matter that can now be put right, but we recognise the distress this caused and this underlines the need for prisons to be fully sensitive to the needs of bereaved families.