

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stephen Davison a prisoner at HMP Wealstun on 8 July 2015

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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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 such as this into deaths, due to any cause, including any apparent suicides and natural causes, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened, correct any injustice and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Stephen Davison was found hanged in his cell at HMP Wealstun on 8 July 2015. Mr Davison was 27 years old. I offer my condolences to Mr Davison's family and friends.

Mr Davison had been at Wealstun for only two weeks before his death. The investigation found that he was appropriately assessed for risk of suicide and self-harm when he arrived at the prison and I am satisfied that staff made a reasonable assessment that there was little evident risk. During his time at the prison, he gave no indication that he was feeling suicidal, either to staff, other prisoners or his family. There is no evidence that he has taken any drugs. I do not consider that staff at Wealstun could have predicted or prevented his death.

While this would have not changed the outcome for Mr Davison, who had apparently been dead for some time, I am concerned that the officer who first opened his cell on the morning of 8 July, did not check to see that he was all right at the time.

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

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Nigel Newcomen CBE
Prisons and Probation Ombudsman

May 2016

Contents

Summary

The Investigation Process

Background Information

Key Events

Findings

Summary

Events

1. On 21 April 2015, Mr Stephen Davison was remanded to HMP Leeds, charged with burglary. On 12 June, he was sentenced to 20 months in prison. He transferred to Wealstun on 26 June. It was not his first time in prison.
2. At an initial health screen at Wealstun, Mr Davison said he had never self-harmed or tried to kill himself and had no thoughts of suicide or self-harm. The nurse assessed his risk factors for suicide and self-harm, but concluded he did not appear to be a high risk of harming himself.
3. In telephone calls to his mother and ex-partner, Mr Davison spoke about the future, including arranging visits and said that he had applied for a bricklaying course. He gave no indication that he felt suicidal.
4. On the morning of 8 July, an officer unlocked Mr Davison's cell but did not check on his wellbeing at the time. At 8.40am, another officer locking the cells found Mr Davison had hanged himself in his cell. Staff did not attempt to resuscitate him, as it was apparent that he had been dead for some time.

Findings

5. During the short time he was at Wealstun, staff did not identify any concerns about Mr Davison. He was described as very quiet, but he seemed to have positive relationships with other prisoners on his wing. He had made no complaints and there was no evidence he was being bullied or in debt. A toxicology report concluded that he had not taken any drugs before he died.
6. We are satisfied that staff properly assessed Mr Davison and there was nothing to indicate that he was at high risk of suicide and self-harm. We do not consider that staff at Wealstun could have predicted or prevented Mr Davison's death. We are concerned that the officer who first unlocked Mr Davison's cell on the morning of 8 July, did not check his welfare. While it does not appear that this would have altered the outcome for Mr Davison, early intervention in other circumstances could help save a life. We consider that staff made an appropriate decision not to attempt resuscitation, as it appears he had been dead for some time.

Recommendation

- The Governor should ensure that, when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.

The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Wealstun informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
8. The investigator visited Wealstun on 14 July 2015. She obtained copies of relevant extracts from Mr Davison's prison and medical records.
9. NHS England commissioned a clinical reviewer to review Mr Davison's clinical care at the prison. The investigator and the clinical reviewer interviewed seven staff and two prisoners on 11 August 2015.
10. We informed HM Coroner for West Yorkshire (Eastern District) of the investigation. We have sent the coroner a copy of this report. Our investigation was suspended in December 2015, to await the outcome of toxicology tests. We regret the consequent delay in issuing this report.
11. One of the Ombudsman's family liaison officers and the investigator visited Mr Davison's family, on 22 September, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They had some questions about the circumstances of Mr Davison's death, which we have aimed to answer in this report. Mr Davison's family did not comment on the initial report. The prison's action plan is attached.

Background Information

HMP Wealstun

12. HMP Wealstun is a category C prison near Wetherby, West Yorkshire, which holds up to 832 men.

Her Majesty's Inspectorate of Prisons

13. The report of the most recent inspection of HMP Wealstun in August 2015, has yet to be published. In preliminary feedback, inspectors found that Wealstun had a detailed database with a wide range of historical data about bullying. The standard of suicide prevention monitoring had improved and the paperwork completed to a very good standard. The previous inspection in August 2011, found that levels of self-harm were low and the quality of the suicide and self-harm prevention documents was generally satisfactory.

Independent Monitoring Board

14. 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. The IMB at Wealstun has not produced an annual report for the past six years.

Previous deaths at HMP Wealstun

15. The last self-inflicted death at Wealstun was in 2013. There were no significant similarities with the circumstances of Mr Davison's death.

Key Events

16. On 21 April 2015, Mr Stephen Davison was remanded to HMP Leeds, charged with burglary. He had been in prison before and his previous prison medical records noted that he appeared to be healthy, with no physical, mental health or substance misuse issues.
17. At an initial health screen at Leeds, the nurse noted that Mr Davison appeared relaxed. The nurse recorded that Mr Davison was over 25 years old, in contact with his family, had no history of mental illness, and was not on remand for a serious charge. Mr Davison said he had no history or thoughts of attempting suicide or self-harm. He said he had no concerns about his physical health and did not abuse drugs or alcohol. On 22 April, a second health assessment noted no concerns about Mr Davison's health.
18. On 5 May, Mr Davison was convicted. On 12 June, he was sentenced to 20 months imprisonment. His release date was 31 December 2015.
19. On 24 June, Leeds assessed Mr Davison as suitable for transfer to a lower security prison. Managers at Leeds took account of information that he had taken mephedrone (MCAT, a stimulant) in the past, although he was not a regular drug user and said he had not used drugs for a long time. On 26 June, Mr Davison transferred to Wealstun. His escort record noted that he had taken drugs in the past, but identified no other risks or issues.
20. At an initial health screen, Nurse A noted that Mr Davison was confident and had no concerns about his health. He had no thoughts of suicide or harming himself, and there were no apparent risk factors linked to suicide or self-harm, such as his first time in prison, or recent drug and alcohol use. This was Mr Davison's last contact with a member of healthcare staff.
21. Mr Davison had a single cell on B Wing. Officer A assessed Mr Davison as part of the prison's first night procedures. He told the officer that he had no immediate or pressing problems, or concerns about being at Wealstun and said he had never self-harmed or attempted to take his life. Mr Davison was waiting for Leeds to transfer his private cash of £21.55 and received an advance supply of tobacco and some telephone credit until his money arrived. Officer B noted in Mr Davison's case notes that a peer advisor (another prisoner) had spoken to him on 30 June, but he had not raised any issues.
22. On 1 July, Mr Davison telephoned his mother for about eight minutes and told her that he felt stressed and had smoked all the tobacco from his advance pack. He said that he had missed the day for ordering canteen (items from the prison shop, such as tobacco and additional food). He said he had applied to do a bricklaying course. That afternoon, he called his ex-partner twice and spoke briefly to his children.
23. On 4 July, Mr Davison spoke to his mother again and she said she would send him a postal order. He explained how to book a visit at Wealstun. (His mother,

his ex-partner and children had last visited him at Leeds on 21 June.) Mr Davison said he felt down, but did not say why.

24. On 5 July, an officer introduced herself to Mr Davison as his personal officer. (Personal officers are expected to get to know prisoners they are responsible for, act as a first point of contact for any problems, help with resettlement issues and make regular entries in the records about a prisoner's progress.) The man's personal officer noticed that Mr Davison was very quiet, but he told her he had no concerns.
25. Mr Davison's last telephone call was to his ex-partner, at 10.41am on 5 July. The call lasted almost six minutes. Mr Davison said he had been playing pool and was 'not too bad', but that it was boring on the wing. He asked why she had not visited or written to him and she said that she did not know where the prison was. Mr Davison explained how to book a visit. They spoke about his release on 31 December and how the children were missing him. Mr Davison said that he had felt sick, but did not know why.
26. On the evening of 7 July, Mr Davison played pool with another prisoner. The prisoner told the investigator that Mr Davison was very quiet and played without saying much. He said that Mr Davison had looked depressed every day, but would not say why. The prisoner said that Mr Davison had not taken any drugs on the wing, was not in any debt to other prisoners and had not been bullied.
27. The night patrol officer on B Wing that night, said that no one had passed on any concerns about prisoners to him when day staff handed over to him. He said nothing unusual had happened during the night.

8 July 2015

28. Between 5.30am and 5.40am, the night patrol officer checked that all the prisoners on the wing were present in their cells, as a routine security count. As it was dark, he used a torch to look into the cells. He could not recall anything unusual in Mr Davison's cell, but said that he would have probably have noticed if he was out of bed at the time.
29. At 8.00am, Officer D and Officer C unlocked the prisoners on B Wing. Officer D said she unlocked Mr Davison's door, but she could not recall looking into his cell.
30. At approximately 8.35am, Officer C started to check the cells to ensure that prisoners with jobs had gone to work and to lock up the other remaining prisoners in their cells. He looked through the observation panel on Mr Davison's cell door at about 8.40am and saw that Mr Davison had hanged himself.
31. Officer D called out to Officer C and went straight into the cell. Mr Davison had used a ligature made of light fabric, possibly the drawstring of a prison kit bag and attached it to pipes in the right corner of the cell. Officer C cut the cord from round Mr Davison's neck.

32. Officer D arrived in seconds, closely followed by two other officers, Officer E and Officer F. Officer D said that Mr Davison's arms and legs looked purple and his body was rigid. Officer E helped Officer C lift Mr Davison's body to the bed. Officer D radioed for healthcare assistance and radioed a code blue emergency (recorded in the emergency log at 8.42am). After receiving the call, the officer in the control room telephoned immediately for an ambulance. (Although we would usually expect Officer C to have called a code blue as soon as he found Mr Davison hanged, we recognise that his immediate reaction was to go into the cell and cut the ligature. Officer D was nearby, so there was no significant delay in calling the code blue.)
33. Officer A also went to the cell. She noticed that Mr Davison's skin was cold and his body was rigid. She asked the other staff to check for signs of life, but thought it was clear that Mr Davison had already died.
34. Nurse A said she heard the call for healthcare assistance, followed immediately by a code blue. Nurse A, Nurse B and a healthcare assistant went immediately to B Wing. They took an emergency bag, oxygen and a defibrillator. Nurse A said they arrived at approximately 8.45am.
35. Both nurses checked Mr Davison, but found no signs of life. He felt cold, his arms were stiff, there was pooling of blood in his arms and legs and his tongue was enlarged. He had a deep mark around his neck caused by the ligature. The prison's resuscitation policy states that resuscitation is not appropriate if a prisoner has features of irreversible death, such as rigor mortis. The nurses agreed that Mr Davison had died and that cardiopulmonary resuscitation was not appropriate. Paramedics arrived at the cell at 8.50am, and recorded that Mr Davison had died.

Contact with Mr Davison's family

36. At 9.00am on 8 July, the deputy governor asked a custodial manager and Officer G to act as family liaison officers. The family liaison officers went to see Mr Davison's mother, who he had named as his next of kin, but she was not at home. They called her mobile phone every 15 minutes, but got no reply. They telephoned the prison for advice and a manager told them to try other contacts listed in Mr Davison's prison record. After first trying Mr Davison's two sisters, they telephoned his ex-partner, who gave them his mother's work address.
37. At 1.20pm, the family liaison officers went to see Mr Davison's mother at her workplace and broke the news to her and offered condolences and support. They spoke to Mr Davison's ex-partner again to offer support. She said she had good support from her family. In line with Prison Service instructions, the prison contributed to the costs of the funeral, which was held on 24 July.

Support for prisoners and staff

38. The deputy governor debriefed the staff involved in the emergency response, to give them the opportunity to discuss any issues arising, and to offer her support and that of the staff care team.

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

Post-mortem report

40. The post-mortem report was not available at the time of issuing this report. However, a toxicology report concluded Mr Davison had not taken any drugs, including synthetic cannabinoids (new psychoactive substances) before he died.

Findings

Assessing Mr Davison's risk

41. Prison Service Instruction (PSI) 64/2011, covering safer custody, lists a number of risk factors and potential triggers for suicide and self-harm. These include early days in custody, young prisoners, being charged with a domestic violence, substance misuse and a history of mental health problems. New prisoners must be assessed in reception so staff can assess their risk of suicide or self-harm and act appropriately to address any concerns, including beginning suicide and self-harm monitoring procedures if necessary.
42. In a PPO thematic report, published in April 2014, about risk factors in self-inflicted deaths, we identified that, too often, assessments of risk place insufficient weight on known risk factors and too much on staff perceptions of the prisoner's behaviour and demeanour. We are satisfied that Nurse A, who assessed Mr Davison on the day he arrived at Wealstun, properly considered his risk factors and concluded he was not at risk. Other Wealstun staff we spoke to, about Mr Davison, had no concerns about him.
43. There was no external information from the court, police or Leeds prison about any previous risk associated with Mr Davison, and nothing to indicate that he had previously self-harmed or attempted suicide. This was not Mr Davison's first time in prison and he knew his release date was 31 December 2015, just over five months after the day he died.
44. Mr Davison was not a known drug user. After his death, one prisoner suggested that he might have used 'spice' a new psychoactive substance, shortly before he died, but a toxicology tests found no evidence of this. He had not complained of being bullied, being in debt, or being under pressure from other prisoners for any reason.
45. During his last telephone calls to his mother and ex-partner, Mr Davison spoke of the future. He explained how to book a visit and was looking forward to seeing his children. He said he had applied to join a bricklaying course and asked for money and stamps to be sent to him. There was no indication that Mr Davison was not looking to the future.
46. Mr Davison's actions seem to have been sudden and unexpected. He left no note to explain why he had killed himself. As he had few known risk factors for suicide, we do not consider that staff at Wealstun could have predicted or prevented his death.

Unlocking prisoners

47. When Officer D unlocked Mr Davison's cell at approximately 8.00am, she did not see him or get a response from him. At approximately 8.40am, Officer C found Mr Davison hanged. As rigor mortis was present, it would appear that Mr Davison was already dead at the time Officer D unlocked his cell.

48. When officers unlock cells they should take active steps to check on a prisoner's well-being. The Prison Officer Entry Level Training (POELT) manual states:

“Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead.”

49. Prison Service Instruction 10/2011 states that:

“Reports from the Prisons and Probation Ombudsman on deaths in custody have identified cases in which a prisoner has died overnight...but staff unlocking them have not noticed that the prisoner has died. This is not acceptable...”

“[Differing] arrangements will depend on the local regime, but there needs to be clearly understood systems in place for staff to assure themselves of the well-being of prisoners during or shortly after unlock....Where prisoners are not necessarily expected to leave their cell, staff will need to check on their well-being, for example by obtaining a response during the unlock process.”

50. While it would not have prevented Mr Davison's death, in other circumstances a failure to get a response from a prisoner or check on their well-being when unlocking a cell could lead to a delay in attending to or treating a seriously ill prisoner. We make the following recommendation:

The Governor should ensure that, when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.