Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of a prisoner at HMP & YOI Hatfield on 25 February 2015

A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

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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*

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.

The man was found hanged in Bawtry Woods in Doncaster on 25 February 2015, while he was a prisoner at HMP Hatfield. He was 43 years old. I offer my condolences to the man's family and friends.

The prison had received some information that he man was involved in using and dealing in drugs, which may have made him a target of bullying by other prisoners. I do not consider that the prison investigated these allegations sufficiently thoroughly. This meant that opportunities to support the man might have been missed. It appears that the man, who was serving an indeterminate sentence, was frustrated about his lack of progress towards release, and had had several previous setbacks. However, he gave no indication that he was contemplating suicide and I do not think that staff at the prison could reasonably have predicted or prevented his actions.

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 **September 2015**

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Summary

Events

1. In May 2006, the man was convicted of robbery and assault and received an indeterminate sentence for public protection. He was released on licence twice (once in 2011 and again in 2012) but breached his licence conditions and was recalled to prison. On 21 November 2013, the man transferred to Hatfield. He had a history of substance misuse but chose not to engage with the substance misuse team.

2. In January 2014, the man began working five days a week at an animal sanctuary, and staff there thought highly of him. The man was waiting for date for a parole hearing, which was a source of anxiety and frustration.

3. In June 2014, a prisoner alleged that the man was using and dealing drugs in the prison, and that he had made himself a target for other prisoners. Staff searched him once but found nothing. In February 2015, another prisoner made a similar allegation. Staff searched the man and, again, found nothing. In January, the man had tested positive for medication he was not prescribed, but the charge was dropped on a technicality.

4. On 24 February, the man left for work as usual. Staff at the animal sanctuary had no concerns about the man during the day and he left there at about 3.15pm. At about 7.00pm, prison staff realised that the man had not returned from work, in breach of his licence conditions. They informed the police that he was unlawfully absent.

5. The next morning, 25 February, the man was discovered hanged in an area of woodland behind the sanctuary.

Findings

6. We are concerned that the prison did not respond adequately to the allegations that the man was bringing drugs into the prison and that the searching policy was

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not sufficiently rigorous. We are also concerned that the prison did not properly investigate claims that the man was being threatened or bullied.

7. Although the man was subject to strict licence conditions, when he was out at work there was little monitoring of his start and finish times at the animal sanctuary and arrangements for transport to and from work were very flexible. This would have made it much easier for the man to get hold of drugs, and delayed efforts to find him when he did not return on 24 February.

8. We have considered whether, on the information available, staff should have identified the man as at risk of suicide. However, we accept that the man showed no particular signs of increased risk in the days leading to his death, and staff could not reasonably have predicted his actions.

Recommendations

- The Governor should ensure that all information indicating bullying, intimidation and use of drugs is fully coordinated and investigated and that those suspected of involvement are appropriately challenged and monitored.

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The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Hatfield informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

10. The investigator visited Hatfield on 4 March 2015. She obtained copies of relevant extracts from the man's prison and medical records. She also visited the man's workplace, interviewed his colleagues, and spoke informally to prisoners on his unit.

11. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison. The investigator and clinical reviewer interviewed seven members of staff and two prisoners at Hatfield on 16 April.

12. We informed HM Coroner for South Yorkshire East District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

13. One of the Ombudsman's family liaison officers contacted the man's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. The man's mother was concerned that her son was involved in drug dealing, and wondered how he had been able to get them. She thought this might have led other prisoners to bully him. She asked about the circumstances of the man's death, and whether the prison and the police should have found him sooner.

14. The man's family received a copy of the initial report. They raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

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Background Information

HM Prison and YOI Hatfield

15. HMP &YOI Hatfield is a category D open resettlement prison that holds 260 young and adult men who are within two years of the end of their sentence.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Hatfield was in October 2012. Inspectors reported that Hatfield was a generally safe prison and incidents of self-harm or violence were rare. However, more prisoners than they expected reported feeling unsafe or victimised. Few staff had received suicide and self-harm prevention training and inspectors identified a need for a violence reduction and anti-bullying strategy.

17. Inspectors noted that the security at Hatfield was proportionate, although the number of mandatory drug tests was low and did not reflect the full picture of illegal drug use at the prison. Prisoners told inspectors it was easy to obtain drugs.

Independent Monitoring Board

18. 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 2014, the IMB reported that there had been some outbreaks of extremely violent behaviour, which they considered a serious safety issue. The Board praised the resettlement department for its work helping prisoners on release on temporary licence.

Previous deaths at HMP and YOI Hatfield

19. The man's death was the first self-inflicted death at Hatfield since this office took over responsibility for investigating deaths in prisons in 2004.

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Key Events

20. In May 2006, the man received an indeterminate sentence, for public protection for robbery and assault, with a minimum period to serve of 22 months before he could be considered for release. In 2011, he was released on licence, but was recalled to prison after committing criminal damage. He was released on licence again in 2012, but was recalled again after being drunk and missing his curfew. In November 2013, the man was recategorised as a category D prisoner (the lowest security category, meaning he was suitable for an open prison). He transferred to Hatfield on 21 November 2013.

21. When he arrived at Hatfield, the man said that he had never harmed himself or suffered with depression. He said he had never been monitored under Prison Service suicide and self-harm prevention procedures. (In fact, he had been monitored for four days in 2012. He told staff preparing reports for the Parole Board that he had harmed himself 'years ago'.) The man said that he had a history of drug and alcohol use and a nurse referred him to the substance misuse team. The man decided not to engage with the team at the time.

2014

22. On 2 January 2014, the man asked for a one-to-one session with a substance misuse worker, but then decided he did not want any help.

1. On 10 January, the man became eligible for community work and applied for a placement at a nearby animal sanctuary. His offender manager, assessed him as suitable for day release on temporary licence. On 27 January, a senior prison manager, agreed that the man was suitable to work at the sanctuary.

2. The man's licence conditions stipulated that he should not leave his place of work; should return immediately to the prison if he finished work early; was not allowed access to a mobile telephone or social networking; was not allowed to travel to Blackpool; must not purchase any items without permission, or go to a public house or betting shop. The man was not allowed to take any controlled drugs, other than those prescribed for him, and had to spend at least 24 hours in the prison each week.

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3. The man started work at the sanctuary at the beginning of February, and was expected to work five days a week (although he sometimes worked six), from 8.30am to about 3.30pm. Prison staff checked the man monthly, either by visiting the sanctuary or by requesting a report from sanctuary staff.

4. The man was waiting for a parole hearing to assess his suitability for release. The offender manager had applied for a hearing date between September 2014 and March 2015, but had not received a date before the man died. The man was anxious about the parole process and shared his frustrations with prison and sanctuary staff.

5. On 5 June, the doctor prescribed the man co-codamol, an opioid painkiller, for chronic leg pain. Two weeks later, the man returned to the healthcare department, worried that he had lost a lot of weight. The nurse who saw him suggested that this might be because he was worried about parole. She offered to refer him to the mental health team, but he did not answer. She suggested he think about it and let her know. The man continued to be prescribed co-codamol on a repeat prescription. He did not ask to be referred to the mental health team.

6. On 28 June, a prisoner submitted a note to the security department in which he named several prisoners who, he said, had flooded the man's room and caused a drink bottle to explode outside his room. He said that the man had made himself a target by bringing heroin into the prison. (The prison said that there had been a number of incidents of indiscipline on the unit one particular day, but that other information suggested that the man was not a specific target.) The prisoner said the man had been using heroin as well as supplying it to other prisoners. Because of the allegations, the security department instructed staff to search the man when he returned to the prison from work. They did not specify when or how many times staff should search the man.

7. On 2 July, staff conducted a rub down search of the man when he got back from work, but found nothing. They did not ask the man about the allegation that he was involved in supplying and using drugs and they did not investigate this any further. No one asked the man if he felt at risk, or was a victim of bullying and there is nothing to indicate that the man told anyone that he was being bullied.

8. On 13 July, the man tested positive for opiates during a random mandatory drug test (unrelated to the prisoner's allegations that the man was using drugs) and was charged with a disciplinary offence. Healthcare staff thought this was

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consistent with the prescribed co-codamol. The charge was dismissed when the sample was re-tested and showed only the presence of co-codamol.

9. On 27 July, prison staff reviewed the man's work placement. They noted that staff at the sanctuary said he worked well and that there was no evidence that he had breached his licence conditions. (They did not refer to the allegation that he had been using and supplying drugs.) They agreed that the man could continue his placement. No one raised any further concerns over the next few months.

10. On 12 November, the man asked for a doctor's appointment because he was feeling very stressed and did not think his medication was helping his leg pain. On 1 December, a doctor, suggested that they reduce the dose of co-codamol and begin a low dose of amytriptyline (an antidepressant also used to treat chronic or neuropathic pain). A week later, the man returned the amytriptyline to the health care department and said it gave him a headache. He asked for another doctor's appointment and continued with his previous dose of co-codamol.

11. The man was approved for release on temporary licence from 19 to 23 December. He stayed at approved premises (probation hostel) in Doncaster to help him prepare him for his eventual release. The man's stay at the approved premises was uneventful and staff had no concerns about him.

12. On 29 December, a doctor prescribed a compression stocking and gel for the man's leg pain. On 5 January, the man had an appointment with the doctor, but he did not attend. The reason was not recorded.

2015

13. On 14 January 2015, the man spoke to a substance misuse worker because he had just had another random drug test and was anxious that it would be positive again because of his medication. He was worried that he might be sent back to a closed prison as a result. The man agreed to see the substance misuse worker again if he needed any support. He saw her again on 21 January, but had not had the test results. They discussed his previous drug use, but he did not say whether he was currently using drugs. The substance misuse worker told the investigator that she had no concerns about the man

14. On 20 January, the man phoned his offender manager, the offender manager, and they agreed he would apply for another period of release on temporary

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licence for four nights, from 23 February to 27 February at the same approved premises in Doncaster.

15. On 23 January, the man received the result of the drugs test, which showed he had tested positive for opiates. Later that day, a prison manager, opened a disciplinary hearing and the man pleaded not guilty to using a controlled substance. He explained that he was prescribed co-codamol and the prison manager adjourned the hearing while the sample was further tested.

16. On 7 February, the security department received an anonymous note reporting that the man often came back from his work placement with drugs that he passed to another prisoner to distribute. Staff searched the man's room, but found nothing. They did not search the man when he got back from work. A security custodial manager, said that, in any event, such searches would usually be just a rub down search, which would be unlikely to find anything.

17. On 11 February, the prison manager received the results of the man's drug test that confirmed the presence of dihydrocodeine, an opiate painkiller, which he was not prescribed. However, due to a technical error in the paperwork, the prison manager had to dismiss the charge. No one asked the man where he had obtained the dihydrocodeine or investigated further.

18. On 23 February, the approved premises in Doncaster asked the offender manager whether the man would be staying, as they had not heard anything from the prison. The offender manager spoke to the man who told her that he had not applied for temporary release as he was fed up with waiting for his parole hearing, which had not yet been listed. The offender manager told the investigator that there had been a national delay in processing parole documentation and setting up hearings and such delays were common.

19. The man also told the offender manager that he could not afford another period of temporary release at the hostel and he only had one pair of shoes, which were falling apart. He said he was unwilling to ask his family for any more help. The offender manager said she would try to help him and advised that he needed another period of release to demonstrate to the Parole Board that he could be trusted to abide by the rules of the approved premises. The man agreed to make an application and get back in touch with her.

24 February 2015

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20. At about 8.30am on 24 February a member of staff who was working in the prison's resettlement office, gave the man his temporary release licence for the day. The member of staff said that the man seemed his normal self. The man handed in his room key to an officer as usual and The officer said he did not notice anything out of the ordinary.

21. Another prisoner worked as a prison driver, taking prisoners to and from their work placements. The prisoner dropped the man at the animal sanctuary at around 8.45am and planned to collect him again at around 3.00pm. As he got out of the van, the man said that, if he was not waiting at the end of the lane that afternoon, The prisoner should not worry as sanctuary staff would drop him off later. The prisoner said this was not unusual as the man often worked late and, when that happened, staff from the sanctuary took him back at the prison.

22. One of the sanctuary managers, said that the man spent the day gardening, hanging flower baskets and other general work. She said that they talked about work and future projects and she had had no concerns about him.

23. According to a statement he made after the man's death, another manager at the sanctuary talked to the man at about 1.30pm. The sanctuary manager thought the man looked a bit low and had done so for a while. The sanctuary manager thought this was because of the man's parole situation, which they had discussed before when the sanctuary manager had driven him home after work. The man had said that he was unhappy about how long the parole process was taking and that he was still waiting for a hearing date. The sanctuary manager said that the man often talked about his mother and his son, and seemed to have plans for the future. He did not have any particular concerns about the man after their conversation.

24. At 3.00pm, the prisoner arrived to collect the man. As he was not waiting at the agreed place, the prisoner went to pick up other prisoners.

25. The man left work at about 3.15pm. As he left, he put his head around the office door, as he always did, and said he would see them tomorrow. The other manager saw him walk out of the gate towards the lane.

26. At 7.10pm, a member of staff, who was working in the prison's gatehouse and checking off prisoners returning from work, told Supervising Officer (SO) that the man had not returned to the prison. The SO phoned the manager, who said that the man had left the sanctuary at his usual time.

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27. Two SO's began contingency arrangements for a temporary release failure (when a prisoner does not return to the prison in line with their agreed licence conditions). One SO contacted the duty governor, the prison manager, and spoke to the prisoner, the last person from the prison to see the man. The SO contacted the police and alerted the Prison Service nationally. In the meantime, staff checked the man's room for any indications that he might have absconded, but found nothing. Prisoners with rooms close to the man's said that he had not seemed his usual self when he had left for work that morning.

28. The police considered the man to be a low risk to the public and noted he had been successfully working outside the prison every day. They did not, therefore, begin an immediate search. At 8.50pm, the local police circulated information about the man to other police forces in the area and checked his last known address in Doncaster. The police also visited the approved premises where the man had stayed previously.

25 February

29. At approximately 7.00am on 25 February, two members of the public found the man hanged from a tree in Bawtry Woods, close to the animal sanctuary. They called the police. The ligature was made from blue rope, which he had taken from the sanctuary. Paramedics, the police and fire service arrived shortly after and paramedics pronounced the man dead.

Information received after the man's death

30. Later on 25 February, a prisoner, told his teacher that the man's room had been searched a couple of weeks earlier and that an officer had said that the man's 'card was marked' and he would not be at Hatfield much longer. The prisoner thought that another prisoner had told the man this. The teacher passed the information to a prison manager. The prisoner did not want to be interviewed as part of our investigation.

31. The next day, 26 February, another prisoner, submitted information to the security department. He said that the man had felt low in recent weeks because he had not been granted parole and had tested positive for drugs. Although the disciplinary charge against him had been dismissed because of an error, he felt that his 'card was marked' (both prisoners used the same expression). The prisoner told the investigator that, the night before he died, the man had shut his room door at 7.00pm, which was unusual. The next morning, he had left for work

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without saying goodbye to anyone, which was also unusual. Another prisoner said that the man's grandmother was dying and that the man had been very upset about this.

32. Prison staff cleared the man's room and sent his property to his family. Included in the property was an undated and, apparently, unfinished letter the man had written to the Governor. The man's mother sent a copy of the letter to the investigator and to the prison. In it, the man wrote that he was being bullied because he chose to spend his time at work. He wrote that drug dealers tormented him and that his room had recently been flooded. It is not clear if this was the same incident the prisoner referred to in June 2014, and he had begun to write the letter much earlier, or if the man's room had been flooded again. The prison had no record of the man's room having been flooded, and, as noted, the man had not reported coming under any pressure from other prisoners.

Contact with the man's family

33. As the man was found dead outside the prison, the police broke the news of his death to his mother. In line with Prison Service guidance, the prison contributed to the costs of the funeral.

Support for prisoners and staff

34. The prison manager debriefed the staff who knew the man and those involved in reporting him missing. The staff care team and managers offered support.

35. The prison posted notices informing other prisoners of the man's death, and offering support. Staff and Samaritans were available to speak to prisoners who had been affected by the man's death.

Post-mortem report

36. The man died from hanging. A toxicology report found the presence of codeine, paracetamol and morphine in his body. It is possible that the morphine was derived from codeine but it could also have come from another source such as heroin. Buprenorphine (a heroin substitute, commonly prescribed as subutex) and gabapentin, (sometimes used to treat nerve pain) were also detected, although the man was not prescribed either.

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Findings

Allegations of bullying, drug dealing and drug use

37. In June 2014 and in February 2015, prison staff received information that the man was making himself a target by bringing drugs into the prison. In July 2014, he had one rub-down search when he returned from work, which found nothing. Staff took no further action to investigate the allegation and did not question the man. In February 2015, after receiving a further allegation, staff searched his room. Again, staff found no drugs or other unauthorised items and did not take any further action. Prisoners at Hatfield are not routinely searched when they return from work placements and local instructions about searching prisoners who work outside the prison say that searches are intelligence led and targeted. This means that prisoners are searched depending on information given to the security department.

38. The man worked up to six days a week at the animal sanctuary and prison staff checked the man monthly, either by visiting the sanctuary or by requesting a report from sanctuary staff. Staff at the sanctuary were very positive about the man's attitude, work and reliability. The man was usually expected to work between approximately 8.30am to 3.15pm, although these times were flexible. A prison driver was supposed to collect him from the sanctuary each day, although he did not have to be back at the prison until 7.00pm and we were told that he sometimes worked late when a member of sanctuary staff drove him back to the prison. The flexibility of the arrangement meant that it was possible that the man could go elsewhere after work before returning to the prison and allow him the opportunity to obtain drugs and other goods as other prisoners alleged. This meant it would have been difficult for prison staff to police his compliance with all his licence conditions. However, we accept that a degree of trust is involved when allowing prisoners in open prisons to attend work placements and it would be difficulty to monitor all movements.

39. One prisoner, a friend of the man, told the investigator that the man was using drugs and might have been targeted as a result, because other prisoners did not like the smell. Another prisoner said that other prisoners paid the man to bring contraband goods, including drugs into the prison. The man did not formally complain to staff that he was being bullied, but he wrote in his unsent letter to the Governor that other prisoners were bullying him. The letter was undated, so we do not know when he wrote this. We recognise that the man never formally

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reported to staff that he was being bullied but we are concerned that the prison did not properly investigate the information they received about his possible involvement in bringing drugs into the prison and associated bullying. We consider that one rub-down search and one room search was an inadequate response to the information and should have resulted in more on-going monitoring. We make the following recommendation:

The Governor should ensure that all information indicating bullying, intimidation and use of drugs is fully coordinated and investigated and that those suspected of involvement are appropriately challenged and monitored.

Assessing the man's risk of suicide and self-harm

40. The man apparently had never attempted suicide and had no recent history of self-harm. While he was at Hatfield, staff had no concerns about his risk of suicide and self-harm, or considered that he needed to be monitored under Prison Service suicide and self-harm prevention procedures.

41. However, the man had several sources of anxiety. As noted above, he wrote that he had been bullied (although there is no information that this was happening at the time of his death). There were also some indications that he might have been involved in drug use and dealing. He was anxious and frustrated that he had not yet received a parole hearing date and about his recent drug test, although the charge against him had been dismissed. The offender manager, staff at the sanctuary and other prisoners knew that parole was a major source of concern for him.

42. The man also complained about leg pain throughout his time at Hatfield and was prescribed co-codamol. Several times, the man told healthcare staff that the medication was not helping. The man tested positive for dihydrocodeine earlier in February, and the post-mortem report noted traces of the drug in his body, which might suggest that he was self-medicating.

43. Although staff missed some opportunities to support the man, we note that there were no clear signs that the man was contemplating suicide in the days leading to his death or that he appeared significantly depressed. Staff at the sanctuary who saw him on 24 February had no particular concerns about him. We do not

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think that, on the evidence we have seen, prison staff could reasonably have predicted his actions.

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Action plan

No	Recommendation	Accepted / Not accepted	Response	Target date for completion and Function Responsible	Progress (to be updated after 6 months)
The Governor should ensure that all information indicating bullying, intimidation and use of drugs is fully coordinated and investigated and that those suspected of involvement are appropriately challenged and monitored.	**Accepted**	The establishment has introduced a contact support officer scheme which focuses on the importance of every contact, ensuring prisoners feel supported and informed using effective communication and language. Prisoners are encouraged to share any issues and concerns as well as building trust and understanding though good communication. On the first day of arrival each prisoner is informed of	**Head of Residence** **Head of Residence**	**Complete** **October 2015**	

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	who their contact support officer is as part of their induction. During that first week, each support officer holds an introductory meeting to begin building a rapport and therapeutic relationship. The support officer is available throughout their sentence to discuss any concerns and offer appropriate support and signposting. A deputy arrangement is in place should there be any long term sick issues, this is quality assured through a custodial manager and functional head. The establishment	**Head of Residence** **Head of Residence** **Head of Security** **Heads of Offender Management Unit, Security, and Reducing Reoffending** **Head of Reducing Reoffending/OMU July 2015**	**Complete** **October 2015** **Completed** **Complete** **Complete**

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		received additional funding to allow an officer to support safer custody procedures and substance misuse services in April 2015. This will be reviewed in April 2016.
		A community concern initiative is being launched in October that gives prisoners the opportunity to inform the prison if they are concerned about a fellow prisoner. A community concern from is available on each wing and once completed is placed in the complaints box for daily collection. All information will be acted upon in a timely and respectful manner

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In June 2015 peer support for substance misusing prisoners was introduced. Four prisoners have been trained in basic drug awareness, group work skills, and addiction and Narcotic Anonymous principles. The Recovery Champions are available to give support to any prisoner with issues relating to substance misuse. They hold weekly Narcotic and Alcohol Anonymous meetings in the evening to allow access to all prisoners.

All allegations of bullying and violence are investigated thoroughly. A region wide

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	case management model was launched in August 2015. This process allows each incident to be investigated and appropriate referred to a weekly Safety Intervention Meeting. All perpetrators and victims are allocated a case manager who will develop a care package to monitor, support and educate appropriately. Security intelligence is shared appropriately with staff to ensure action is taken that is proportionate. The use of suspicion testing is utilised where intelligence is received, and risk based drug testing has	

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	been introduced for those prisoners accessing release on temporary licence (ROTL). An integrated approach to information sharing and risk management of ROTL has been introduced, which includes Offender Management, security and reducing reoffending functions. A Prison Service Instruction (PSI) on ROTL was implemented in July 2015, and the prison is acting in accordance of the requirements of this PSI, which includes frequency checks on work placements and guidance on partnership	

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	agreements between the work placement and the establishment.

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