Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Anthony Hill a prisoner at HMP & YOI Hindley on 6 March 2017

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*

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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 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.

Mr Anthony Hill was found hanged in his cell at HMP & YOI Hindley on 6 March 2017. He was 35 years old. I offer my condolences to Mr Hill's family and friends.

The investigation found that Mr Hill had never given any indication of suicidal thoughts throughout his time in custody. I am satisfied that staff at Hindley could not have predicted or prevented Mr Hill's actions.

However, I am concerned at the evident availability of illicit drugs at Hindley and share the concerns of HM Inspectorate of Prisons and the Independent Monitoring Board about this issue.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **October 2017**

Contents

Summary 1
The Investigation Process 2
Background Information 3
Key Events 4

Summary

Events

1. On 6 December 2016, Mr Anthony Hill was remanded into custody at HMP Preston charged with grievous bodily harm. Mr Hill had been in prison before. On 6 January 2017, he was convicted and sentenced to 27 months imprisonment. Mr Hill was transferred to HMP & YOI Hindley on 24 January 2017.

2. Mr Hill had never harmed himself and no one had ever considered that he was at risk of suicide. Mr Hill had a history of alcohol and drug use and had agreed to receive support from substance misuse rehabilitation services

3. At 10.55am on 6 March 2017, an officer found Mr Hill hanging in his cell and called an emergency. The officer began cardiopulmonary resuscitation (CPR) until paramedics arrived. The paramedics took over emergency treatment but at 11.28am pronounced Mr Hill dead.

Findings

Assessment of risk of suicide and self harm

4. Mr Hill had given no indication either verbally or in terms of how he presented to staff, other prisoners, or his family that he had thoughts of suicide. We do not consider that prison staff could have predicted his actions.

Illicit Substances

5. We are concerned, however, that Mr Hill obtained illicit drugs at Hindley and, on his own admission, had used cannabis while at Preston. The post mortem report confirmed that Mr Hill had taken an illicit prescription drug. As Mr Hill was not prescribed this drug, it is likely he had obtained it illicitly from another prisoner.

Emergency Response

6. Staff did not use the appropriate emergency code on finding Mr Hill. However we are satisfied that this would not have changed the outcome for Mr Hill.

Recommendations

- The Governor should ensure there are effective supply and demand reduction strategies to help reduce the availability of illicit substances, including the trafficking of prescription medication, and that staff are vigilant to signs of their use and know how to respond when a prisoner appears to be under the influence of such substances.
- The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013, *Medical Emergency Response Codes,* and their responsibilities during medical emergencies, which ensures a medical emergency code is used.

The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP & YOI Hindley informing them of the investigation and asking anyone with relevant information to contact him. No one responded but four prisoners were interviewed at the investigator's instigation.

8. The investigator visited Hindley on 13 March. He obtained copies of relevant extracts from Mr Hill's prison and medical records.

9. NHS England commissioned a clinical reviewer to review Mr Hill's clinical care at the prison.

10. The investigator interviewed ten members of staff and four prisoners at Hindley in March, jointly with the clinical reviewer.

11. We informed HM Coroner for Greater Manchester West District of the investigation. He gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.

12. One of the Ombudsman's family liaison officers contacted Mr Hill's family to explain the investigation and to ask whether they had any matters they wanted the investigation to consider. As Mr Hill was a drug user, his family wanted to know what assessment and medication he received to assist his withdrawal. Mr Hill's family believed that Mr Hill's ex-partner visited him using a false identity, despite a restraining order preventing Mr Hill from having any contact. The family asked how this could have happened. Mr Hill's family received a copy of the initial report. The solicitor representing Mr Hill's family wrote to us pointing out some factual inaccuracies and/or omissions. The report has been amended accordingly. They also raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

Background Information

HMP & YOI Hindley

13. HMP & YOI Hindley was formerly a young offender institution (YOI). In 2015, it became a category C prison for adult men sentenced to less than four years imprisonment, and young adults aged 18-21 serving sentences between 12 months and four years. It can hold up to 664 men. Bridgewater NHS Foundation Trust provides physical health services, while Greater Manchester West NHS Trust provides mental healthcare.

HM Inspectorate of Prisons

14. The most recent inspection of HMP & YOI Hindley was conducted in July 2016. Inspectors found that the regime at Hindley was one of the worst, and possibly the very worst, that inspectors had ever seen in this type of prison. Inspectors commented that the length of time that prisoners were locked up was unnecessary, unjustifiable and counterproductive. Almost every aspect of prison life for the prisoners was adversely affected by the regime.

15. Inspectors found that the levels of drug misuse were high. Prisoners told inspectors it was easier to get hold of drugs in Hindley than it was to get clean clothes, sheets or books from the library. Inspectors found high levels of violence, often fuelled by the destructive effects of drugs, particularly New Psychoactive Substances (NPS), which were not controlled or minimised by the regime that was in place. If anything, it exacerbated these problems.

16. Inspectors found that clinical and psychosocial services were of a good quality and very well integrated. However, regime curtailment reduced access to group work and diminished positive outcomes for prisoners. Mental health services were good, providing both primary and secondary care through an appropriate mix of psychiatry, mental health nursing and clinical psychology. There was an appropriate range of services, including self-help, counselling, psychological therapies and interventions for men with complex mental health needs.

Independent Monitoring Board

17. 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 most recently published report for the year to December 2016, the IMB was greatly concerned with the use of NPS in the prison, which contributes to debt, bullying and violence. The IMB commented that good intelligence has led to interceptions and finds of a substantial amount of NPS. Despite this, drugs still remain widely available.

Previous deaths at HMP & YOI Hindley

18. Mr Hill’s death was the third self-inflicted death at Hindley since January 2016. The previous death was from natural causes. There are no similarities between these deaths and that of Mr Hill.

Key Events

19. On 6 December 2016, Mr Anthony Hill was remanded to HMP Preston charged with inflicting grievous bodily harm. Mr Hill had been in prison before. He also had a history of cocaine, cannabis and alcohol abuse. Mr Hill had no history of self-harm and was not prescribed any medication by his doctor in the community.

20. On arrival at Preston, a nurse saw Mr Hill and carried out an initial health screen. Mr Hill said he felt fit and well. He was not taking any prescribed medication but did use cream for eczema. He said he had not drunk alcohol for approximately four weeks. She recorded that Mr Hill denied any thoughts of self-harm or suicide and had not received any medication for mental health problems. She recorded that Mr Hill had eczema on his feet.

21. An officer saw Mr Hill to conduct his first night interview. She recorded in Mr Hill's prison computer record that she had explained all avenues of available help and advice to Mr Hill, and he said he had no thoughts of self-harm or suicide.

22. During the morning of 7 December, a nurse saw Mr Hill for a second health screen. Mr Hill said he had no thoughts of self-harm or suicide. He said he smoked six cigarettes a day. She recorded that Mr Hill was prescribed cream for eczema. Preston received Mr Hill's records from his doctor in the community and these confirmed that his only prescribed medication was cream for eczema.

23. An officer saw Mr Hill to complete the second day reception interview. He recorded that he had explained the prison regime to Mr Hill, described what areas of support were available to him and that Mr Hill had no issues or concerns.

24. That afternoon a mental health nurse saw Mr Hill for a mental health assessment. Mr Hill said he felt anxious and had trouble relaxing. He said he had stopped drinking alcohol after he was arrested but previously drank heavily at weekends. Mr Hill said he was anxious about being away from his family and child. He denied any thoughts or plans of self-harm or suicide. She recorded that there was no indication that Mr Hill had any mental health issues and he was at no risk to himself or others. She referred Mr Hill to substance misuse services.

25. On 6 January 2017, Mr Hill appeared at Crown Court, where he was convicted of inflicting grievous bodily harm. He was sentenced to 27 months imprisonment. The court also issued a Restraining Order, preventing Mr Hill from having any direct or indirect contact with the victim, his ex-partner, and forbidding him from approaching her address, or that of her parents and sister.

26. On 23 January, a prison doctor saw Mr Hill as he complained of being in low mood, anxious and not sleeping. Mr Hill said he was doing "okay" since he had been sentenced and had a supportive family. He denied any thoughts of self-harm or suicide. She prescribed mirtazapine (an anti-depressant), and arranged for Mr Hill to be reviewed in two to three weeks time.

27. On 24 January 2017, Mr Hill was transferred to HMP & YOI Hindley. A nurse saw him and carried out an initial health screen. Mr Hill said he was a cigarette smoker, drank alcohol every night and had used cocaine. She recorded that Mr

Hill denied any thoughts of self-harm or suicide, had eczema and noted that he was prescribed mirtazapine.

28. An officer saw Mr Hill to conduct his first night interview. Mr Hill said that he was happy to be at Hindley and had no issues. She recorded that Mr Hill had no thoughts of self-harm or suicide.

29. On 26 January, a nurse saw Mr Hill for a second health screen. He recorded that there were no concerns with Mr Hill's physical health, his appetite was normal and he had no thoughts of self-harm or suicide.

30. On 3 February, Mr Hill saw a substance misuse support worker. Mr Hill said that he used to drink alcohol six days a week and also used cocaine. She explained to Mr Hill the various group work options available at Hindley. Mr Hill agreed to engage with substance misuse support. She recorded that she had completed the initial assessment paperwork and that Mr Hill had been added to the waiting list.

31. On 9 February, a prison doctor saw Mr Hill to review his prescription of mirtazapine. Mr Hill said that his mood was low and he used cannabis and alcohol in the community. He denied any thoughts of self-harm or suicide. The doctor recorded that Mr Hill had mild depression and advised him to continue with the mirtazapine for a further six weeks and he would be reviewed again. He also prescribed zerobase cream (for eczema).

32. On 14 February, a mental health nurse saw Mr Hill for a mental health assessment. Mr Hill said he was in prison for an act of violence against his long-term partner. He said he used cocaine, cannabis and alcohol while in the community. Mr Hill said he had never self-harmed and denied any thoughts of self-harm. He said he attended work but spent much of the rest of his time in his cell, as he did not want to mix with other prisoners. She recorded that Mr Hill was anxious and in low mood because of his guilt over his offence. She referred Mr Hill for one-to-one support from a psychological wellbeing practitioner to help him manage his anxiety and worry.

33. On 21 February, prison records confirm that Mr Hill was visited by female visitor. Mr Hill's family allege that this person was actually Mr Hill's ex-partner who used a fake identity to gain entry to the prison. The investigator has been unable to substantiate the allegation made Mr Hill's family.

34. On 23 February, as a result of the referral made by the nurse, Mr Hill saw a psychological wellbeing practitioner. Mr Hill said he could not forgive himself for his actions that led him to be in prison, and was finding it hard to adjust. He said he felt he was in shock over his behaviour, which was out of character, and also because his relationship was over. She recorded that Mr Hill expressed an interest in attending the wellbeing and relaxation group and wanted to improve his mood. Mr Hill said that he was anxious and wanted to move to a different wing, as he wanted to be in a single cell.

35. On 1 March, staff organised a move for Mr Hill from D wing to A Wing, where he was initially allocated a shared cell. A member of the safer custody team saw Mr Hill after he had arrived on A Wing. Mr Hill said he was very anxious as he did

not want to share a cell. She arranged for Mr Hill to see a Listener and arranged for Mr Hill to move to a single cell. (Listeners are Samaritan-trained prisoners who provide confidential support to fellow prisoners.) She asked the psychological wellbeing practitioner to see Mr Hill later that day. She recorded that Mr Hill had no thoughts of self-harm or suicide.

36. The member of safer custody told the investigator that Mr Hill found it difficult to settle in prison because of his guilt over his offence and the breakdown of his relationship with his ex-partner. She said that at no point did Mr Hill give any indication that he had thoughts of self-harm or suicide.

37. Later that day, the psychological wellbeing practitioner saw Mr Hill as requested by the member of safer custody. Mr Hill said that he had moved wings, was now in a single cell and he was much happier. He said he realised that sharing a cell was the root of his anxiety. Mr Hill said he had no further problems and did not want any further appointments. She recorded that Mr Hill agreed to see her three weeks later to check whether he required any ongoing support.

38. The psychological wellbeing practitioner told the investigator that Mr Hill was upbeat and positive and was adamant that he did not need any additional support. She said it was standard practice to have a follow-up session with prisoners in case they changed their mind and did want additional support.

39. A prisoner, who was also a Samaritan-trained Listener, told the investigator that he had spoken to Mr Hill six times during the time Mr Hill was living on A Wing. Mr Hill told him about his offence, the length of his sentence and the fact that he had spoken to the mental health team. He said that Mr Hill was very anxious and could not settle on A wing. He said he was not aware that Mr Hill used illicit drugs.

40. On 2 March, Mr Hill told staff he was unable to cope on A wing and wanted to move back to D wing. An officer recorded in Mr Hill's prison computer records that staff and the safer custody team supported Mr Hill's request and he was moved back to a single cell on D wing that day.

41. On 3 March, an offender supervisor saw Mr Hill to discuss his sentence plan. Mr Hill said that he was not doing well and was unhappy at Hindley. He said he wanted a move to another prison. She discussed a sentence plan with Mr Hill and set him targets of: achieving enhanced prisoner status, of engaging with substance misuse services and of attending daily activities. She told Mr Hill she would look into the possibility of his transferring to another prison.

42. The offender supervisor explained to the investigator that Hindley did not run courses to address domestic violence behaviour and these courses were offered at other prisons. However, as Mr Hill's conditional release date was less than 12 months away, he would more probably undertake such courses when back in the community. She also explained that Mr Hill was made aware of the Restraining Order preventing him from having any contact with his ex-partner and that due to the nature of his offence Social Services would be involved concerning contact with his daughter.

43. On 4 March, an officer saw Mr Hill in his capacity as his personal officer. He explained that the role of the personal officer was to assist prisoners with any problems or issues that they might have. He recorded that Mr Hill was very anxious, so he arranged for Mr Hill to speak to a Listener. He said Mr Hill was a standard prisoner, had a job in the recycling workshop, was not in debt and had not raised any issues or concerns with him.

44. Another prisoner and trained Listener told the investigator that he spent an hour with Mr Hill. He said that Mr Hill was very anxious and paranoid. Mr Hill told him he had concerns about access to his child once he was released and that he did not trust the mental health team. He said he believed nothing was confidential and this would adversely affect his time in prison. He said that at no point did Mr Hill give any indication that he had thoughts of self-harm or suicide.

45. Prison records show that on 4 March Mr Hill had a visit from his mother, sister and daughter. On 5 March, he called his mother at 10.05am. The investigator has listened to this call, which lasted 1 minute and 19 seconds. Mr Hill said he could not cope without seeing his daughter and asked his mother to bring his daughter to the next visit. He said still loved his ex-partner, but his mother said his ex-partner no longer loved him. Mr Hill gave no indication he had thoughts of self-harm or suicide.

46. A fellow prisoner told the investigator that he lived in the next cell to Mr Hill. He said that Mr Hill kept himself to himself and was in regular contact with his family. He said on the morning of Mr Hill's death he went to Mr Hill's cell door and asked Mr Hill for cigarette papers. He said that Mr Hill was on his bed and said he did not have any cigarette papers. He then went to work.

47. Another prisoner also told the investigator that he lived in the other cell next to that of Mr Hill. He also said Mr Hill kept himself to himself. He said he was aware Mr Hill had used "weed" but not NPS. He said that on the day before his death, Mr Hill had obtained a mobile phone from another prisoner and tried to call someone. He could not get through so he gave the phone back. He said that on the morning of Mr Hill's death, as he went to work, he saw, through the observation panel, Mr Hill "messing" with the light fitting.

48. At 8.00am on 6 March, an officer began to unlock the prisoners on Mr Hill's landing. He told the investigator that when he unlocked Mr Hill's cell, Mr Hill had refused to go to work so he re-locked the cell door. He returned to the landing at 10.30am to deliver the post and newspapers to prisoners.

49. The officer told the investigator he arrived at Mr Hill's cell at 10.55am to deliver two newspapers. As these would not fit under the cell door, the officer opened it. He found Mr Hill suspended from the light fitting by a ligature made from bedding. He shouted for staff assistance. Staff immediately responded, cut the ligature, radioed to summon urgent medical assistance and immediately started cardiopulmonary resuscitation (CPR). The prison communications log shows that the radio call was made at 10.55am and the 999 call was made immediately. A custodial manager immediately responded and assisted with CPR.

50. Within two minutes healthcare staff arrived and took over the CPR and used an automated external defibrillator. (This monitors the heart rhythm and administers

electrical shocks to restore the normal rhythm when necessary.) It found no shockable heart rhythm.

51. North West Ambulance Service records show that the paramedics arrived at the prison at 11.06am, and took over Mr Hill's care at 11.07am. At 11.28am, the paramedics pronounced Mr Hill dead.

52. Mr Hill had left a suicide note addressed to his mother and family. He wrote he was sorry that he had taken the decision to take his own life, but he was unable to cope anymore.

Contact with Mr Hill's family.

53. The Deputy Governor and the prison family liaison officer visited Mr Hill's mother at her home at 12.15pm. They broke the news that Mr Hill had died and offered their condolences. While at the family home, the police were called as the family liaison officer was assaulted by Mr Hill's brother and the Deputy Governor's car was blocked in, preventing them from leaving the area. In the days that followed the family liaison officer maintained contact with Mr Hill's sister and, in line with Prison Service instructions, the prison contributed to the costs of the funeral.

Support for prisoners and staff

54. The Head of Safer Custody debriefed the staff who had been involved in the emergency response. Staff members were offered the support of the prison's care team.

55. The prison posted notices informing staff and prisoners of Mr Hill's death, and offering support. Staff reviewed all prisoners subject to suicide and self-harm prevention procedures in case they had been adversely affected by Mr Hill's death.

Post-mortem report

56. A post-mortem examination confirmed that the cause of Mr Hill's death was hanging. The pathologist commented that the toxicology results found the presence of therapeutic levels of mirtazapine and high therapeutic levels of zopiclone (for insomnia). As Mr Hill was not prescribed zopiclone, it is likely he had obtained it illicitly from another prisoner.

Findings

Assessment of risk of suicide and self-harm

57. Mr Hill had been in prison before. He had a history of substance misuse but had no history of suicide attempts or self-harm. At no time during his sentence was Mr Hill considered at risk of suicide, such that he needed additional monitoring and support using Prison Service suicide and self–harm prevention procedures.

58. Mr Hill gave no indication to anyone that he had any suicidal thoughts immediately prior to 6 March or at any other time while he was at Hindley. Several staff each told the investigator that Mr Hill had given no indication that he had any thoughts of self-harm. We do not consider that staff at Hindley could have predicted that Mr Hill intended to take his life.

Illicit Substances

59. Mr Hill admitted his history of drug use to both prison and nursing staff. He agreed to work with substance misuse recovery groups at the prison. Wing staff and Mr Hill's offender supervisor said Mr Hill had not given them any indication that he was using drugs, in debt or being bullied.

60. We are concerned that Mr Hill had used cannabis at Preston and, as the post-mortem report confirmed, had obtained an illicit drug while at Hindley. Mr Hill was not prescribed zopiclone at any point during his time at Hindley. The most likely way he could have obtained it was illicitly from another prisoner who had been prescribed it by prison doctors. A prisoner told the investigator that Mr Hill used "weed". It is not possible to say whether Mr Hill's actions were influenced either directly or indirectly by drug use. Nevertheless, we make the following recommendation:

    The Governor should ensure there are effective supply and demand reduction strategies to help reduce the availability of illicit substances, including the trafficking of prescription medication, and that staff are vigilant to signs of its use and know how to respond when a prisoner appears to be under the influence of such substances.

Clinical Care

61. The clinical reviewer considered that the standard of care Mr Hill received while in custody was equivalent to that he could have expected in the community. He was satisfied that Mr Hill required no intervention for withdrawal from alcohol or drugs, he received appropriate psychosocial support for drug and alcohol abuse and received appropriate treatment, intervention and medication for depression.

Emergency Response

62. PSI 03/2013, *Medical Emergency Response Codes,* issued in February 2013, contains mandatory instructions for efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It explicitly states that all prison staff must be made aware of, and understand, this instruction and their responsibilities during medical emergencies. The PSI also includes a mandatory

instruction that the terms of the medical emergency response protocols must be written and agreed in conjunction with the local healthcare commissioner at the prison and the local ambulance trust.

63. When the officer shouted for staff assistance, staff immediately responded and called for urgent medical assistance when Mr Hill was found hanging in his cell at 10.55am on 6 March. Staff correctly cut Mr Hill down and immediately started CPR and the staff in the control room immediately called for an ambulance.

64. North West Ambulance Service records show they received the 999 call at 10.55am, paramedics arrived at Hindley at 11.06am and took over Mr Hill's care at 11.07am. While staff did not use an emergency code, it caused no delay to the emergency response or in calling for an ambulance. However, an emergency code should have been used. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013, *Medical Emergency Response Codes,* and their responsibilities during medical emergencies, which ensures a medical emergency code is used.

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