Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Wayne Nelson a prisoner at HMP Humber on 1 September 2016

A report by the Prisons and Probation Ombudsman
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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.

Mr Wayne Nelson died in his cell at HMP Humber on 1 September 2016. He had hanged himself. He was 42 years old. I offer my condolences to Mr Nelson's family and friends.

Mr Nelson had longstanding issues with drugs and had, in the past, suffered from mental health problems. He had been in prison before. On arrival in Humber in April 2016, he was properly assessed by the healthcare team and referred to the mental health and detoxification teams.

Although it appears that Mr Nelson continued to use illicit drugs at HMP Humber, I am satisfied that he did not give any indication to staff or other prisoners that he would take his own life.

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 **June 2017**

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Summary

Events

1. Mr Wayne Nelson was remanded in custody in August 2015. He had been in prison before. He had a history of drug and alcohol misuse. He had no history of self-harm but had suffered from mental health problems in the past. When he transferred to HMP Humber in April 2016, he engaged with the substance misuse team. His physical health was good.

2. On one occasion, prison officers suspected Mr Nelson of being under the influence of some substance, but when healthcare staff assessed him they found him to be fine.

3. Mr Nelson applied to transfer to HMP Lincoln but this was turned down as Humber was preparing him for release. He seemed to settle well. In June, he spoke to his partner on the telephone and appeared to be under the influence of something, but when tested for drugs again, in July, he passed the test. In August, he told his partner that he had been clear of drugs for some weeks.

4. Mr Nelson's friends said that, about a week before he died, he had told them that he had spoken to his partner on the telephone and discovered that she had been unfaithful. Recordings of Mr Nelson's telephone calls do not, however, include any such conversation.

5. On the morning of 1 September, when the night officer conducted a roll check, she found Mr Nelson hanging. She called an emergency, but when staff went into his cell Mr Nelson had clearly been dead for some time so resuscitation was not attempted.

Findings

Assessment of risk

6. Mr Nelson had no history of attempted suicide or of self-harm. During his stay in Humber, he did not give any indication, or give staff any reason to suspect, that he was a threat to himself.

Drugs

7. Mr Nelson had issues with drugs and alcohol, and had been involved in the drug culture in previous prisons. However, he was working with the substance misuse team in Humber. He passed a drug test in July 2016 and told his partner on the telephone that he had stopped using drugs. Accordingly, staff had little reason to think he was using drugs, but post-mortem tests showed a level of dihydrocodeine (an opioid-based pain-killer) in his system that he had not been prescribed.

Bullying

8. Mr Nelson complained that he had been threatened in the workplace and was concerned that he might inherit a debt from a former cellmate. However, there is

no further intelligence to suggest that Mr Nelson was concerned about or at risk from bullying.

Healthcare

9. The clinical reviewer considered that Mr Nelson received a high standard of healthcare in prison. He gave no sign of having any mental health problems or of being at risk of harming himself. She noted that staff could not have predicted his actions and made no recommendations.

Emergency response

10. When the night officer found Mr Nelson hanging she called an emergency. Despite this, nobody entered Mr Nelson's cell or called an ambulance for four minutes. It would appear clear that Mr Nelson was already dead, so this did not affect the outcome. Such a delay could, however, do so in future emergencies.

11. When the nurse assessed Mr Nelson she rightly judged that it would not be appropriate to attempt to revive him.

Contact with Mr Nelson's family

12. When Mr Nelson died, there were no trained family liaison officers available. Nevertheless, his family was informed in a timely and appropriate manner, and a trained family liaison officer was subsequently appointed.

Recommendations

- The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that:
  - night staff enter cells as quickly as possible in a life-threatening situation;
  - control room staff request an ambulance as soon as an emergency code is called.
- The Governor should ensure that an appropriate member of staff is appointed promptly to liaise with bereaved families.

The Investigation Process

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

14. On 16 September, the investigator visited Humber. He obtained copies of relevant extracts from Mr Nelson's prison and medical records. He interviewed four prisoners at Humber.

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

16. We informed HM Coroner for Kingston upon Hull and the East Riding of Yorkshire of the investigation. He sent us the results of the post-mortem examination and we have given the coroner a copy of this report.

17. One of the Ombudsman's family liaison officers wrote to Mr Nelson's mother to explain the investigation and to ask whether Mr Nelson's family had any matters that members wanted the investigation to consider. Mr Nelson's family did not raise any specific issues. Mr Nelson's family received a copy of the initial report. They did not make any comment.

Background Information

HMP Humber

18. HMP Humber is a medium security prison in Yorkshire that holds approximately 1,000 men. It was formed in 2014 by the merger of two previously separate prisons, HMP Wolds and HMP Everthorpe. City Health Care Partnership provides healthcare services.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Humber was conducted in July 2015. Inspectors noted the increased availability, and use, of illegal drugs. Levels of self-harm were not high, however, and prisoners reported positive relationships with staff.

Independent Monitoring Board

20. 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 2015, the IMB reported that the prison was addressing difficulties that resulted from the merger. The board were impressed by the efforts of the prison to counter the use of new psychoactive substances, (NPS).

Previous deaths at HMP Humber

21. Mr Nelson's death was the fourth self-inflicted death in 2016. We have previously raised concerns about delays in entering cells and summoning ambulances in emergency situations, both of which have a bearing in this case.

New Psychoactive Substances (NPS)

22. New psychoactive substances, previously known as 'legal highs' are an increasing problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of NPS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

23. In July 2015, we published a Learning Lessons Bulletin about the use of NPS and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

24. NOMS now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements. Testing has begun, and NOMS continue

to analyse data about drug use in prison to ensure new versions of NPS are included in the testing process.

Key Events

25. On 31 August 2015, Mr Nelson was remanded to HMP Lincoln. He was facing trial on charges of aggravated burglary, assault occasioning actual bodily harm, and possession of an offensive weapon. He had been in prison before. Mr Nelson had no history of self-harm but did have a history of drug and alcohol misuse, and had suffered mental health problems after the death of his father in 2011. He had been prescribed anti-depressant medication between 2011 and 2015, but at his reception health screening in Lincoln he said he had no thoughts of harming himself and declined a referral to the mental health team. He was referred for a detoxification programme with the prison's Integrated Drug Treatment System (known as IDTS), and was prescribed methadone (a heroin-substitute medication). In September, however, Mr Nelson reported depression, anxiety and paranoia. He was referred to the mental health team. Mr Nelson asked if he could again be prescribed anti-depressants, and this was agreed.

26. Mr Nelson settled reasonably well at Lincoln, but was suspected of being involved in the prison's drug culture. In October, he failed a random drug test, showing positive results for benzedrine, methadone and cannabis. In December, staff thought him to be under the influence of drugs. In February, having been convicted of the charges he was facing, he was sentenced to two years and four months imprisonment. In March, he told his offender supervisor that he had not taken heroin for 10 years but was still taking methadone as part of his IDTS treatment. Later that month, a prison officer thought him to be under the influence of something and at the end of the month he failed another drug test, showing positive results for cannabis. On 4 April, Mr Nelson and another prisoner told a member of staff that they were being threatened.

27. On 7 April, Mr Nelson was transferred to HMP Humber. At his reception screening the nurse noted his ongoing substance misuse issues, but that his physical health was good. Mr Nelson told the substance misuse team that he would like to engage with the drug and alcohol rehabilitation service, and continue with his prescription of methadone.

28. On 20 April, prison officers thought that Mr Nelson might be under the influence of some substance, but when healthcare staff checked him he appeared to be behaving normally, displaying no physical symptoms. On 29 April, he told a member of staff that he could not go to work as two prisoners who worked there had threatened him. On several occasions during May, Mr Nelson did not attend work. He said he was suffering from problems with his back, although healthcare staff were unable to confirm whether this should keep him from work.

29. On 5 June, Mr Nelson told a prison officer that he was worried about having inherited a debt from a cellmate who had moved. He said he was worried that he might be attacked. Mr Nelson put in an application to the safer custody department, reiterating his fears that he was in danger in his workplace. They asked the activities department to find him alternative employment.

30. On 14 June, Mr Nelson applied for a transfer to Lincoln, which was his home town. This was refused, as Humber was a resettlement prison and was preparing him for release at the end of October. On 19 June, his records show

that he had started work as a wing cleaner and had a new cellmate, with whom he got on.

31. On 19 June, Mr Nelson spoke to his partner on the telephone. She commented that he appeared to be under the influence of something. He said that it would be different once he had left prison. He told her that he was in debt and asked her to send him some money. He spoke to her again later that afternoon, when he appeared to say "I'm out of my head". On 21 June, he spoke to her again, and asked her to ask his mother to send him some money.

32. On 14 July, Mr Nelson passed a drug test, and on 17 August he was promoted to the enhanced level of the incentives and earned privilege scheme which allows prisoners certain privileges, and is designed to encourage and reward good behaviour.

33. On 19 August, Mr Nelson telephoned his partner. They argued, and he told her that he had "been off Mamba eight weeks". (Mamba is an NPS commonly used in prisons.) In another call later that day, he said that he hadn't "touched Mamba in about six weeks".

34. Mr Nelson's friends said that about a week before he died, he told them that he had spoken to his partner on the telephone and discovered that she had been unfaithful. Recordings of Mr Nelson's telephone calls, however, do not include any such conversation.

35. On 31 August, prisoners were locked into their cells for the night and staff conducted a roll check at approximately 7.30pm. There were no problems with Mr Nelson at that time. Mr Nelson was not on special support measures and was not on any night time medication, so staff had no reason to check on him during the night. He was in a single cell so did not have a cellmate. Cell bell calls are not recorded. There is nothing in the wing observation book indicating any problems with Mr Nelson over the course of the night. The night officer said that she had to conduct checks on a prisoner two cells along from Mr Nelson throughout the night. She said that at no point did Mr Nelson activate his cell bell or try to attract her attention.

36. A prisoner in an adjacent cell to Mr Nelson said that during the night he did not hear anything from Mr Nelson's cell. Another prisoner in an adjacent cell said that, at around 3.00am, he heard scraping noises coming from Mr Nelson's cell. He did not inform any prison staff.

37. On 1 September, the night officer was conducting an early morning roll check. CCTV footage shows that at 5.35am she arrived at Mr Nelson's cell. She looked through the observation panel and saw him hanging from the window bar by a ligature made from a bed sheet. She used her radio to call a code blue emergency, indicating a prisoner unconscious or having trouble breathing. As soon as she made the radio call, the battery on her radio died and she ran to the wing office and up a flight of stairs, to get a replacement.

38. The orderly officer in charge of the prison responded to the code blue call and went to Mr Nelson's cell. CCTV footage showed that he arrived at 5.39am. He unlocked the cell door and he went into the cell. He said in his written statement

that he called to Mr Nelson, and immediately radioed for an ambulance and for staff to attend. Mr Nelson was in a kneeling position, leaning against the wall below the window. He used his anti-ligature knife to cut the bedding, but when he did so Mr Nelson did not change position. He said that he would usually attempt to resuscitate someone, having first laid them on the floor, but he was unable to move Mr Nelson.

39. The officer on duty in the communications room, on hearing the night officer's code blue call, had asked for emergency response staff to attend D wing. However, he had not requested an ambulance. When the orderly officer radioed for an ambulance, he radioed the night officer for some details to pass on to the ambulance service. The communications room record of events showed the code blue call was made at 5.34am, and that an ambulance was requested at 5.40am.

40. A nurse responded to the emergency call and went to D Wing. She checked Mr Nelson for signs of life, but found that he was clearly dead. She judged that attempting to resuscitate him would be futile. When the ambulance crew arrived they made no attempt to resuscitate him and pronounced Mr Nelson dead.

Contact with Mr Nelson's family

41. There were no trained family liaison officers available so, having identified Mr Nelson's mother as his next of kin, the deputy governor and one of the prison's managers visited her to inform her of his death. In line with prison service guidance, Humber offered to contribute to the costs of Mr Nelson's funeral.

Support for prisoners and staff

42. After Mr Nelson's death, the duty governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

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

Post-mortem report

44. The post-mortem report showed the cause of death as hanging. As well as traces of his prescribed medication, toxicology tests found a level of dihydrocodeine (an opioid-based pain-killer) in Mr Nelson's system.

Findings

Assessment of risk

45. Mr Nelson had no history of harming himself. During his stay in Humber he did not give any indication, nor give staff any reason to suspect, that he was a threat to himself. There was nothing in Mr Nelson's record, nor in the wing observation book, that indicated that he displayed any behaviour that should have caused concern.

46. Mr Nelson's friend said that after he had disclosed problems with his partner, Mr Nelson withdrew into himself. He had said that he was missing his home, but not in any way that caused him to be concerned about him. Another friend said that he had not noticed any particular changes in Mr Nelson's demeanour or behaviour.

Drugs

47. There were rumours among prisoners that Mr Nelson did smoke NPS. His friend said in interview that Mr Nelson had used these substances, but had stopped using them around the beginning of July because they were giving him unwelcome thoughts. Mr Nelson, when speaking to his partner on the telephone, appeared to admit that he was taking drugs. Toxicology results showed that he had a level of dihydrocodeine in his system. This is a prescription drug that was not in Mr Nelson's list of prescribed medication.

48. Mr Nelson did have longstanding issues with drugs. He had been involved in the drug culture in prison and had in the past failed drug tests. He did, however, pass the last random drug test he had taken, in July 2016 and was working with the substance misuse team in Humber, in line with their substance misuse strategy. There were no intelligence reports or suggestions among his friends that he had any drug debts, and staff did not have any reason to suspect that he was using drugs when he died.

Bullying

49. In April, Mr Nelson said that he had been threatened in his workplace and, in June, said that he was worried about having inherited a debt from a cellmate who had moved. There is no further intelligence about these observations and Mr Nelson raised no concerns thereafter. He told his partner on the telephone that he was in debt and asked her to send in money, but she told the police that it was not unusual for him to be in debt and he gave her no indication that he was in any significant trouble. His friends on the wing said that he was not being bullied, and there is no intelligence to suggest that Mr Nelson was concerned about bullying.

Healthcare

50. The clinical reviewer noted that Mr Nelson received a high standard of care in prison. He was assessed and referred appropriately on reception, and given the right support for his needs. The clinical reviewer concluded that the healthcare provided to Mr Nelson in Humber was equivalent to that which he could have

expected in the community. He did not appear to be suffering from mental health issues. He had not given any concern that he might harm himself and staff could not have predicted his actions on 1 September. The clinical reviewer made no recommendations.

Emergency response

51. Prison Service Instruction (PSI) 24/2011, *Management and security of nights*, states that staff have a duty of care to prisoners, to themselves, and to other staff. The preservation of life must take precedence over usual arrangements for opening cells and where there is, or appears to be, immediate danger to life, then cells may be unlocked without managerial authority and an individual member of staff can enter the cell alone. Staff are not expected to take action that they feel would put themselves or others in unnecessary danger. What they observe, together with any knowledge of the prisoner, should be used to make a rapid dynamic risk assessment. The night officer found Mr Nelson hanging during a role check. She saw him through the cell observation panel, and called a code blue emergency. As soon as she made the radio call, the battery on her radio died and she ran to the wing office, up a flight of stairs, to get a replacement. She then waited for colleagues to arrive rather than entering the cell alone. The orderly officer said that when he arrived she was clearly in a degree of shock.

52. CCTV footage shows that four minutes elapsed between the night officer calling the emergency code and the orderly officer entering the cell. It would appear that Mr Nelson had already been dead for some time, so in this instance any delay would not have affected the outcome. However, four minutes is a significant length of time between someone being found hanging and staff entering a cell. On another occasion, this could mean the difference between life and death. We understand that staff are in a very difficult situation and have to make instantaneous decisions but we would normally expect prison officers to enter a cell as soon as possible in the hope of saving someone's life.

53. PSI 03/2013, *Medical emergency response codes,* states that governors must have a medical emergency response code protocol to ensure that prisons call an ambulance immediately in a life-threatening medical emergency. The PSI explicitly states that control room staff should automatically call an ambulance whenever an emergency code is called and that it is not necessary for a member of the prison healthcare team or a duty manager to attend the scene before emergency services are summoned. No ambulance was called when the night officer called the code blue emergency. This was only done when requested by the orderly officer on his arrival.

54. It is important that prison staff understand their roles in a medical emergency, as early intervention when someone is found hanging can save a life. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that:

- **night staff enter cells as quickly as possible in a life-threatening situation;**

- **control room staff request an ambulance as soon as an emergency code is called.**

55. When the nurse assessed Mr Nelson, she considered that attempting to revive him would be futile. The clinical reviewer noted that the decision not to attempt resuscitation was appropriate.

Contact with Mr Nelson's family

56. There were no trained family liaison officers available. Staff did go and inform Mr Nelson's family of what had happened in a timely manner, and a family liaison officer was subsequently appointed. The Governor should, however, ensure that bereaved families have as seamless a relationship with liaison staff as possible. We make the following recommendation:

The Governor should ensure that an appropriate member of staff is appointed promptly to liaise with bereaved families.

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