

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jay Power a prisoner at HMP Hull on 1 September 2016

**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 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 Jay Power died in his cell at HMP Hull on 1 September 2016. He had hanged himself with a ligature made from a belt. He was 37 years old. I offer my condolences to Mr Power's family and friends.

Mr Power had been released from prison in May 2015 but was recalled to Hull that November. He engaged with the mental health team and the detoxification services, and seemed to settle back into prison life without problems. On 16 August 2016 he attended a Parole Board hearing but the decision was deferred for further information, and this upset Mr Power. That day, he telephoned his partner and ended their relationship.

Despite Mr Power's disappointment at the delay and subsequent outcome to his Parole Board hearing, and his split with his partner, he gave neither staff nor prisoners cause for concern that he would harm himself.

However, I am concerned that there was a missed roll check on the morning of 1 September, but it would appear likely that Mr Power was already dead by the time it should have been carried out, so this did not affect the outcome. The Governor has since taken disciplinary action against the staff member concerned.

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

July 2017

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Summary

Events

1. Mr Power had been in prison before and released on licence. He was recalled to custody in November 2015. He had a history of drug use and mental health problems. He worked with the prison's detoxification team, although he discharged himself from the care of the mental health team in December.
2. In March 2016, Mr Power was suspected of being under the influence of new psychoactive substances (NPS), formerly known as 'legal highs'. At the end of that month he cut his arm, and staff began to monitor him under Prison Service procedures for those at risk of self-harm. Mr Power said that he was frustrated because he was supposed to be in a single cell. He was promptly moved to a single cell, monitoring procedures were ended the same day.
3. On 16 August, the Parole Board considered Mr Power's request for release. It adjourned the hearing for further reports, which upset Mr Power. Later that afternoon he argued with his partner on the telephone and ended their relationship.
4. During the night of 26 August, Mr Power said he wanted to go to hospital because of pain in his arm. When told this was not possible at night, he said it would be if he were to harm himself. The officer asked if this was his intention but he assured her that it was not.
5. On the evening of 31 August, Mr Power asked a friend to cut his hair. Several prisoners said that he did not appear to be upset or displaying any signs of distress before they were all locked away for the night.
6. On 1 September, the night patrol officer was due to conduct a roll check at approximately 5.30am. She did not do so. When the day officer took over he conducted a roll check and, on checking Mr Power's cell, could not see him properly. Unable to get a response, he called for assistance and staff entered Mr Power's cell and found him hanging. The officers called an emergency, cut Mr Power down and checked him for signs of life. A nurse arrived and examined Mr Power, but concluded that he had been dead for some time. She did not attempt to resuscitate him.

Findings

Assessment of risk

7. Mr Power had been disappointed by the outcome of his parole hearing, and had left a defaced copy of the outcome notification in his cell. He had not, however, given any sign of being disproportionately upset and neither staff nor prisoners thought that he was at risk of harming himself. Mr Power had recently ended his relationship with his partner. Although he mentioned this to his friends on the wing, none thought him likely to harm himself.

Drugs

8. Mr Power had a history of drug use and involvement in prison drug culture. He had apparently used NPS in Hull, but his friends said that he had stopped doing so. How recently was not clear although post-mortem tests did not identify any drugs in his system.

Emergency response

9. The night officer was supposed to undertake a roll check between 5.30am and 6.00am but failed to do so. The Governor identified this and has taken disciplinary action against the officer. When the day officer conducted a morning roll check, he was unable to see or elicit a response from Mr Power, so raised the alarm. As he could not be sure about the situation he was facing, his decision not to enter the cell alone was reasonable. When other staff joined him, they went together into Mr Power's cell. Mr Power had apparently been dead for some time. The clinical reviewer was content that the decision not to attempt to resuscitate him was appropriate.

Mr Power's healthcare

10. The clinical reviewer concluded that Mr Power received a level of healthcare equivalent to that he would have expected in the community.

Recommendations

- We make no recommendations.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Hull informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
12. The investigator visited Hull on 9 September. He obtained copies of relevant extracts from Mr Power's prison and medical records.
13. The investigator interviewed six members of staff and three prisoners at Hull in September and October.
14. NHS England commissioned a clinical reviewer to review Mr Power's clinical care at the prison.
15. 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.
16. One of the Ombudsman's family liaison officers contacted Mr Power's ex-wife to explain the investigation and to ask whether Mr Power's family had any matters which members wanted the investigation to consider. Mr Power's ex-wife asked about Mr Power's mood and medication, and about the emergency response. The family liaison officer also contacted Mr Power's mother to explain the investigation and invite her to raise any matters she wished to be considered. She requested as much detail as possible about the movements of Mr Power on the day before he died, and that any injuries to his body were considered during the course of the investigation.
17. A copy of our initial report was sent to Mr Power's family. The solicitor representing his mother raised a factual inaccuracy which has been amended in this final report. They also raised other queries which do not alter the factual accuracy of our report and have therefore been addressed in separate correspondence.

Background Information

HMP Hull

18. HMP Hull is a medium security prison in Yorkshire that holds approximately 1056 remanded, convicted and sentenced adult men and young offenders. Healthcare is provided by City Health Care Partnership.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Hull was an unannounced inspection that was conducted in October 2014. Inspectors found that the prison had a rigorous drug supply and demand reduction policy, although prisoners said that drugs were available. Levels of self-harm were lower than in similar prisons. Inspectors reported that health services were good, and most prisoners were reasonably satisfied with the quality of, and access, to healthcare.

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 the year 2015, the IMB reported that Hull was an effectively-run prison that provided a safe and decent environment.

Previous deaths at HMP Hull

21. Mr Power was the third prisoner to take his own life at Hull since the beginning of 2015. There were no similarities in the circumstances of these deaths to that of Mr Power. There has since been a further death.

Key Events

22. On 19 November 2015, Mr Power was recalled to prison having been released on licence several months earlier. He was taken to Hull, a prison where he had been before. He had been managed under suicide and self harm prevention procedures (ACCT) some years before and had a history of using drugs. His escort papers noted risks relating to self-harm by cutting and overdosing, violence, opiate addiction and attempts to smuggle drugs. The papers also noted that he had hepatitis C, and had suffered from mental health problems, including anxiety and depression. At a reception health screening, Mr Power was referred to the prison's drug and alcohol detoxification team, and to the mental health team for assessment. The nurse discussed Mr Power's previous self-harm with him, and was satisfied that there was nothing to suggest that Mr Power presented any risk of self-harm at that time.
23. Mr Power worked with the prison's psychiatric wellbeing team, which did not detect any evidence of mental health problems. On 22 December, Mr Power discharged himself from contact. He continued to work with the detoxification team. In February 2016, he asked to move to the Substance Misuse Recovery Unit, but a week later asked to leave, feeling himself to be past the stage of detoxification being addressed on the unit. He remained on a methadone detoxification programme but, on 7 March, was noted to be under the influence of some substance, believed to be NPS. He was placed onto the basic level of the incentives and earned privileges scheme (IEP), designed to encourage and reward good behaviour.
24. On 22 March, Mr Power cut his arm with a razor blade. Staff began ACCT procedures, and Mr Power said that he had felt stressed because he had to share a cell. A prison doctor confirmed that Mr Power should be housed in a single cell, and he was moved to one on C wing the same day. He appeared to settle down, and told staff that when he cut himself he had had no intention to take his own life, he simply felt frustrated. Staff assessed that he no longer posed a threat to himself. The ACCT was closed the same day. At a post-closure interview on 28 March, Mr Power said that the issue had now been addressed, and he felt that he had been supported through the problem.
25. On 26 May, staff suspected Mr Power of concealing his medication - with the presumption that he would sell or trade it. His IEP scheme level was again downgraded.
26. On 29 July, Mr Power asked a member of staff if he would consider bringing a package into the prison. It was not clear whether Mr Power was genuinely trying to persuade the member of staff to do so, or if he was being facetious. No further action was taken.
27. On 16 August, Mr Power attended an oral hearing into his application for release on parole. The panel did not have full details of some issues under discussion, and members also wanted a psychological report. The hearing was therefore adjourned. Mr Power was upset, and his offender supervisor

took him out of the room to calm him down. Mr Power remained upset, and refused to return to the hearing. Later that afternoon, Mr Power telephoned his partner. They had an argument, and Mr Power told her that their relationship was over.

28. On 22 August, Mr Power reported a swelling on his arm, which was diagnosed as cellulitis (a skin infection). He was prescribed antibiotics. A friend of Mr Power said that Mr Power showed him his arm and commented that such things could be fatal. Mr Power replied that that “would be a bonus”. The friend thought he was joking, although he did seem rather downbeat. On 23 August, Mr Power tried to relieve the swelling on his arm by cutting it with a razor. He said that the antibiotics were not working. A nurse dressed the cut, and referred him to the doctor. The following day the doctor prescribed painkillers in addition to his antibiotics and told Mr Power that he could collect them from healthcare if he needed. The doctor made a further appointment for Mr Power that afternoon, but Mr Power did not attend.
29. On 26 August, Mr Power saw a doctor and said that his arm felt much improved and he had no anxieties about it. The doctor told Mr Power to contact the healthcare department if he had any further concerns.
30. When prisoners had been locked into their cells for the night, Mr Power pressed his cell bell and told the night patrol officer that he wanted to go to hospital. He was not happy with the healthcare he had received and wanted a second opinion. The night patrol officer contacted the healthcare department and spoke to a nurse. She said that Mr Power had been seen during the day, he was receiving treatment for his arm, and that he did not need any further treatment at that time. Mr Power was unhappy with this response, so the night patrol officer spoke to the night orderly officer, who was in charge of the prison during the night. She spoke to the nurse. The nurse reiterated that she knew what was wrong with Mr Power, that he was under treatment that needed time to work, and that he was not in any danger. Moreover, he had missed appointments, had not collected any painkillers that day, and that when she came on duty she had been told that she did not need to go and see him.
31. The night orderly officer relayed this to Mr Power. He said that he was worried that the infection in his arm could spread and that he was in danger, and needed to go to hospital. She said that she could not send him out to hospital at that time, as the prison was in night state, when staff levels are lower than during the day, and security measures are different. Mr Power said that this was not true, because if he harmed himself then he would be taken out to hospital. She asked him whether he was threatening to harm himself, and Mr Power said that was not what he meant. He said he was making the point that it was not impossible to send someone to hospital during the night. She said that she would put him on the list to see the doctor in the morning, and he agreed that he would wait.
32. The night orderly officer later spoke to the night patrol officer, who said that Mr Power had gone to sleep and not pressed his cell bell again. The nurse

spoke to the night orderly officer during the night and asked how Mr Power was. She told her that he was asleep and had not asked for any further help.

33. The following morning Mr Power went to the medication hatch and was verbally aggressive towards the nurse. The next day he returned to the hatch and apologised.
34. Prisoners told the investigator that Mr Power had smoked NPS over his time in Hull, but that at the end of August he decided to stop. He wanted to improve his health and started attending the gym. However, he did tell one prisoner that he had given in and smoked some NPS on one day.
35. On the evening of 31 August, a prisoner cut Mr Power's hair and, while he did so, they talked. He said that Mr Power seemed fine. Another prisoner said that he spoke to Mr Power just before they were locked into their cells for the night. Mr Power said he had no tobacco, so he gave him a cigarette. He did not detect anything out of the ordinary about Mr Power. Another prisoner was also a friend of Mr Power and lived in the cell next to him. He said that he also spoke to Mr Power just before they were locked into their cells for the night, and then again about 30 minutes later through the cell windows. He told the investigator that there were no signs that Mr Power was under the influence of anything on either occasion. Prisoners said that he did not appear to be upset or displaying any signs of distress before they were all locked away for the night.
36. At approximately 6.30pm, an officer conducted a roll check. He did not notice anything untoward about Mr Power. He was not subject to special monitoring and did not require any medication during the night, so there was no reason for staff to check on him. Cell bell calls are not recorded, and there is nothing in the wing observation book to indicate that staff were aware of any problems with Mr Power over the course of the night. However, a prisoner told the investigator that during the night he heard some banging noises coming from Mr Power's cell. Another prisoner also said that he heard a loud bang, at approximately midnight.
37. An operational support grade (OSG), was the night patrol officer on C wing. On 1 September, she was responsible for conducting a roll check between 5.30am and 6.00am. CCTV footage, however, shows that she did not check the cells but only patrolled the wing.
38. Officer A took over from the OSG on C wing and, at approximately 7.00am, began his own roll check. CCTV footage shows that at 7.13am he reached Mr Power's cell. He looked through the observation panel and, although the cell was dark, he could see the toilet door was slightly ajar and beneath it could see Mr Power's legs protruding, as if he were sitting on the floor. Thinking that Mr Power had heard him coming and was joking, trying to hide, he kicked the door and called Mr Power's name. On receiving no response he became concerned and used his radio to ask for the orderly officer, who was in charge of the running of the prison, to attend immediately.

39. The orderly officer and a Supervising Officer (SO) responded to the request and arrived at Mr Power's cell within a minute of Officer A's radio message. The officer said that he was concerned, and the orderly officer unlocked the door. They went in and could see that Mr Power had hanged himself from a ligature made from a belt. The orderly officer touched Mr Power's shoulder and called his name, but the officer and SO both said in interview that Mr Power was clearly dead and had been for some time. The orderly officer used his radio to call a code blue emergency, to indicate a prisoner who was unconscious or having difficulty breathing. The officer and SO used an anti-ligature knife to cut Mr Power down and laid him on the floor. The SO checked for signs of life as they did so, but found none.
40. Three minutes after the orderly officer made the emergency call a nurse arrived and examined Mr Power. He was clearly dead, with no pulse, breathing, or heartbeat, and there was evidence of rigor mortis. The nurse did not attempt resuscitation as she felt it would have been futile.
41. When the orderly officer called a code blue emergency, staff in the control room automatically requested an ambulance. At 7.30am the ambulance crew arrived at the cell, and paramedics pronounced Mr Power dead.
42. Officer A searched Mr Power's cell and found a letter from the Parole Board relating to the outcome of Mr Power's hearing. Mr Power had written the word "bullshit" on it.

Contact with Mr Power's family

43. An officer was appointed as family liaison officer. Having identified Mr Power's next of kin, she and one of the prison's managers went to Mr Power's mother's house and informed Mr Power's family of his death. In line with prison service guidance, Hull offered to contribute to the costs of Mr Power's funeral.

Support for prisoners and staff

44. After Mr Power'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.
45. The prison posted notices informing other prisoners of Mr Power'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 Power's death.

Post-mortem report

46. The post-mortem report showed that Mr Power died as a result of hanging. Examinations found no alcohol or illicit substances in Mr Power's system.

Findings

Assessment of risk

47. Mr Power had been upset by the outcome of his parole hearing, and had left a defaced copy of his notification of the outcome in his cell. The letter was dated 26 August, but Hull has not been able to confirm when Mr Power received it. He had talked about being annoyed about the outcome with his friends on the wing. Mr Power's offender supervisor said that he spoke to Mr Power in the days after the hearing and, while Mr Power was obviously disappointed at not being released, his anger dissipated shortly after the hearing. He did not feel that Mr Power had been disproportionately upset and said he certainly had no reason to think that he would harm himself.
48. During the night of 26 August, Mr Power made references to self-harm in conversation with the night orderly officer. She said in interview that she asked him in clear terms whether he was threatening to harm himself, and she was completely satisfied that he was sincere when he said he was not. He said he was using the example of serious self-harm as a situation when the prison could send a prisoner to hospital during the night. She said that if she had had any doubts she would have started ACCT procedures, but she felt that there was no need to do so at that time.
49. Mr Power had ended his relationship with his partner on 16 August, and had mentioned this to some of his friends on the wing. They all, however, said that they had not detected anything to cause them concern on the night of 31 August. Mr Power's death came as a surprise to both staff and prisoners, and there is nothing to suggest that anyone could have anticipated his actions.

Drugs

50. Mr Power had a history of drug use, and had been involved in the drug culture in prison in the past. He worked with the detoxification team when he arrived back in Hull, and had asked to move to the Substance Misuse Recovery Unit in February. He did, however, ask to move off a week later. In early March staff noted that he was apparently under the influence of NPS and, in May, he was suspected of concealing his medication. On 29 July, he asked a member of staff if he would consider bringing a package into the prison, although it was not clear whether this was a genuine approach or an attempt at humour. Prisoners said that Mr Power had smoked NPS and, although he said not long before he died that he intended giving it up, he admitted to having used it on at least one occasion thereafter.
51. There was no intelligence to suggest that Mr Power was using drugs around the time that he died. In their latest inspection, Her Majesty's Inspectorate of Prisons noted that Hull had a rigorous drug supply and reduction strategy. Post-mortem tests did not find any evidence of any drugs in Mr Power's system.

Emergency response

52. On the morning of 1 September, the OSG was due to conduct a roll check, but CCTV shows that she did not do so. She has subsequently been subject to disciplinary procedures.
53. Guidance on emergency codes is contained in Prison Service Instruction (PSI) 03/2013, *Medical Emergency Response Codes*. The instruction states that staff must call a medical emergency code if they find a prisoner experiencing specified symptoms. When Officer A was unable to gain a response from Mr Power he radioed for assistance, but did not use an emergency code. In interview he said that this was because he was unaware of anything to suggest a medical emergency until he went into the cell. He was not in a position to know whether Mr Power met any of the medical symptoms listed in the PSI, and said that he would not go into a cell on his own if he could not see the prisoner. In this case he could see Mr Power apparently sitting on the floor, his arms and upper body hidden behind the toilet door.
54. PSI 24/2011, *Management and Security of Nights*, which covers security at nights, states that staff have a duty of care to prisoners, themselves, and other staff. Preservation of life must take precedence over usual security arrangements but staff are not expected to take action that they feel would put themselves in danger. Officers must make a risk assessment before opening cell doors. Officer A said that if he could see a prisoner hanging in a single cell he would call an emergency and then enter. That was not the case here, but he requested assistance immediately, and when colleagues arrived they went straight into the cell. In the circumstances his decision not to go into Mr Power's cell without back-up was reasonable.
55. When prison officers went into the cell, they cut Mr Power down and called a medical emergency. They checked Mr Power for signs of life and did not attempt to resuscitate him. It seems clear that Mr Power had already been dead for some time by the time staff entered the cell, and when the nurse assessed Mr Power she found no responses. The clinical reviewer noted that the decision not to attempt resuscitation was appropriate.

Mr Power's healthcare

56. The clinical reviewer noted that Mr Power received a good level of healthcare in Hull. He was properly assessed on arrival, referred to the mental health team, and the healthcare team addressed outstanding hospital appointments related to his hepatitis C.
57. Even though he showed no signs of mental illness, the mental health team continued to monitor him until he discharged himself from their care by not attending appointments. During his time in Hull, Mr Power denied any thoughts of harming himself.
58. The clinical reviewer concluded that Mr Power received a level of healthcare in Hull equivalent to that he could have expected in the community.

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