

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Lee Osei, a prisoner at HMP Highpoint, on 23 December 2019

A report by the Prisons and Probation Ombudsman

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*



© Crown copyright 2019

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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 Lee Osei was found hanged in his cell at HMP Highpoint on 23 December 2019. He was 40 years old. I offer my condolences to Mr Osei's family and friends.

In the fortnight before his death, Mr Osei engaged in two acts of antisocial behaviour which might have indicated that he was in debt or being bullied. I am concerned that these were not investigated properly. However, although he also had other risk factors for suicide and self-harm, not all of which were known to prison staff, I consider that there was little to indicate to staff that he was at imminent risk of suicide.

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

Sue McAllister CB
Prisons and Probation Ombudsman

September 2020

Contents

Summary	1
The Investigation Process	3
Background Information	4
Key Events	6
Findings.....	11

Summary

Events

1. On 6 November 2017, Mr Lee Osei was remanded in custody to HMP Pentonville. He was later sentenced to eight years in prison. On 7 December 2018, Mr Osei was transferred to HMP Highpoint.
2. During his first months at Highpoint, prison staff occasionally suspected that Mr Osei had used drugs. Otherwise, his time was relatively uneventful, and Mr Osei was known as a man who spent his time in the gym or studying.
3. On 10 November 2019, staff found Mr Osei collapsed on the floor. They suspected he had taken drugs, although Mr Osei denied this.
4. On 10 December, an officer identified that Mr Osei had taken the television from a prisoner's cell and delivered it to another. The officer told us that this might mean that Mr Osei was in debt, although she did not question him about this at the time. Two days later, a different officer noted that Mr Osei was trying to get into other prisoners' cells and thought he might be trying to steal things. A unit manager spoke to him about this and told us that he took no further action.
5. In the days before his death, Mr Osei spoke to his partner by telephone several times. Some of the conversations were difficult and on 21 December, his partner asked Mr Osei to stop calling her. Prison staff were not aware of the nature of these conversations at the time.
6. At around 1.57pm on 23 December, an officer unlocked Mr Osei's cell after the lunch period but did not check on his wellbeing, as local policy requires. At 2.23pm, another officer went to the cell and found him hanged. Prison staff tried to resuscitate Mr Osei but paramedics later confirmed he had died.

Findings

7. Mr Osei had some risk factors for suicide and self-harm, although not all were known to prison staff at the time. We consider that it would have been difficult for staff at Highpoint to have foreseen his death.
8. However, there is little evidence that prison staff had frequent meaningful contact with Mr Osei, and evidence of antisocial behaviour – which might have indicated that he was in debt or being bullied – was not adequately challenged or investigated. We are therefore concerned that staff did not give themselves the best opportunity to identify any issues that Mr Osei might have had.
9. The officer who unlocked Mr Osei's cell on the afternoon of his death should have checked on his welfare at the time, in line with local instructions.

Recommendations

- The Governor should ensure that all information indicating violence, bullying and intimidation is fully coordinated and investigated and that apparent victims are effectively supported and protected.

- The Governor should ensure that there is an effective keyworker scheme which provides meaningful and ongoing support to prisoners, in line with national policy.
- The Governor should ensure that a copy of this report is shared with the unit manager, Officer A, Officer B and Officer C and that a senior manager discusses the Ombudsman's findings with them.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Highpoint informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
11. The investigator visited Highpoint on 8 January. He obtained copies of relevant extracts from Mr Osei's prison and medical records, and interviewed four prisoners who knew Mr Osei.
12. The investigator interviewed ten members of staff at Highpoint in February.
13. NHS England commissioned a clinical reviewer to review Mr Osei's clinical care at the prison. The clinical reviewer joined Mr Judd for interviews with clinical staff.
14. We informed HM Coroner for Suffolk of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
15. The Ombudsman's family liaison officer contacted Mr Osei's sister to explain the investigation and to ask if she had any matters that she wanted us to consider. Mr Osei's sister asked what he used for a ligature and where he obtained it.
16. We have addressed those questions in this report.
17. We shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.
18. We shared the initial report with Mr Osei's sister. She raised some issues which we have addressed in separate correspondence.
19. We also shared the report with Mr Osei's partner. She did not make any comments.

Background Information

HMP Highpoint

20. HMP Highpoint is a Category C prison in Suffolk, holding up to 1,319 men across two sites (North and South). Care UK provides general and mental health services at the prison.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Highpoint was in August 2019. Inspectors reported that the number of incidents of self-harm had increased but was still lower than at similar prisons. They also reported that incidents of violence had increased, although significantly more prisoners than at similar prisons said they felt safe. Inspectors found that all reported acts of violence were investigated and the prison had a good understanding of the impact that drug use had on debts and violence.
22. Inspectors also reported on excellent working relationships between staff and prisoners.

Independent Monitoring Board

23. 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 to December 2018, the IMB reported that the number of incidents of self-harm had fallen by around seven per cent during the reporting year. The IMB also reported that PS was a significant issue at Highpoint, with the unpredictable behaviour it produced impacting on daily life. They identified that staff were proactive in identifying and searching prisoners believed to be involved in the trafficking of PS.

Previous deaths at HMP Highpoint

24. Mr Osei was the second prisoner from Highpoint to die since December 2017, and the first to take his own life. There are no significant similarities between the circumstances of the other recent deaths and that of Mr Osei.

Assessment, Care in Custody and Teamwork

25. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner.
26. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT

booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Psychoactive Substances (PS)

27. PS (formerly known as 'new psychoactive substances' (NPS) or 'legal highs') are a serious 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 PS 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 PS precipitating or exacerbating the deterioration of mental health, and they are linked to suicide or self-harm.
28. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at that time, 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 PS, the need for more effective drug supply reduction strategies, better monitoring by drug treatment services and effective violence reduction strategies.

Key Events

29. On 6 October 2017, Mr Lee Osei was remanded in custody to HMP Pentonville, charged with kidnap. He had been to prison several times previously.
30. Mr Osei had been prescribed methadone (medication used to treat opiate addiction) and mirtazapine (antidepressant medication) for several years, both of which were continued following his arrival at Pentonville. Prison staff had started ACCT procedures once previously, for eight days during a previous sentence in 2016. On arrival at Pentonville, Mr Osei said he had no thoughts of suicide or self-harm.
31. In June 2018, Mr Osei was sentenced to 11 years in prison. In November, this was reduced to eight years on appeal.
32. From September to November 2018, prison staff recorded on four occasions that Mr Osei appeared to be under the influence of what they suspected was PS.

HMP Highpoint

33. On 7 December 2018, Mr Osei was transferred to HMP Highpoint. He did not raise any issues of concern on his arrival.
34. Mr Osei had slowly reduced his methadone prescription over the previous year. On 17 December, he completed his course and stopped taking methadone. Over the following weeks, substance misuse service staff reviewed him and recorded that he said he felt “as good as he could have hoped”.
35. On 15 February 2019, Mr Osei tested positive for PS at a random drugs test. He told staff that he had not used PS and blamed the failed test on inhaling other prisoners’ smoke. Prison staff reduced him to basic status on the prison’s Incentives and Earned Privileges (IEP) scheme (which aims to encourage and reward responsible behaviour in prisons). Mr Osei returned to standard status a week later.
36. In March, Mr Osei was permitted to visit his father who was terminally ill in hospital. On 3 April, Mr Osei’s father died.
37. On 13 April, prison staff suspected that Mr Osei was under the influence of drugs. Four days later, they again recorded suspicion that Mr Osei had used drugs.
38. On 21 May, Mr Osei approached a substance misuse recovery coordinator and said that he would like to do some relapse prevention work with the substance misuse service. She added Mr Osei to the waiting list for an assessment.
39. On 11 June, a recovery coordinator assessed Mr Osei. She created a care plan with several objectives including completing one-to-one work with the substance misuse service, and referred him for bereavement counselling and to Rethink (who work at Highpoint to provide services to prisoners with mental ill health). In her referral to Rethink, the recovery coordinator identified that Mr Osei experienced “low mood”.

40. On 13 June, a psychological wellbeing practitioner assessed Mr Osei. She recorded that Mr Osei had depression, which he said made him feel lethargic. Mr Osei said that this meant he struggled getting out of bed, fell behind with his studies (Mr Osei was studying for an Open University degree), and did not attend the gym. The psychological wellbeing practitioner placed Mr Osei on the waiting list for low-intensity cognitive behaviour therapy (CBT, a talking therapy used to treat anxiety and depression).
41. On 20 June, prison staff recorded that Mr Osei appeared to be under the influence of drugs. They also recorded that he had not attended education sessions several times recently.
42. On 27 June, prison staff recorded security intelligence that Mr Osei was bringing PS onto the unit on which he lived. The next day, he was moved to a different unit, now on the South site of the prison.
43. On 26 July, a substance misuse recovery coordinator reviewed Mr Osei. She recorded that he said he was well and did not think about using drugs.
44. On 16 August, prison staff upgraded Mr Osei to enhanced status on the IEP scheme.
45. On 27 August, Mr Osei began CBT with the psychological wellbeing practitioner. At the first session, Mr Osei discussed various frustrations that he had with prison life, including his move to the South site, and said that he would like to find strategies to cope with these frustrations other than using drugs.
46. On 2 September, Mr Osei attended his second CBT session. The psychological wellbeing practitioner recorded that Mr Osei said that he was “tired of life and this long sentence” but reported that these were “passive” thoughts and that he had no current thought, plan or intent to take his own life.
47. On 4 September, an officer recorded that he had no issues in prison other than his recent move to the South site. The officer recorded that he also spoke to Mr Osei about his recent poor attendance at education.
48. On 17 September, a recovery coordinator reviewed Mr Osei. Mr Osei told her that he was doing well, was not currently using drugs and needed no further support from the substance misuse service. The recovery coordinator suspended Mr Osei’s substance misuse file.
49. On 23 September, Mr Osei attended his final CBT session. The psychological wellbeing practitioner told us that it was a mutual decision to end the sessions. Over the course of the sessions, tools used to score Mr Osei’s levels of anxiety and depression showed that these had reduced.
50. On 10 November, prison staff found Mr Osei lying on the floor of another prisoner’s cell, having vomited. They suspected that he was under the influence of PS, and asked healthcare staff to attend. A nurse attended, and recorded that Mr Osei had taken PS. The next day, prison staff downgraded Mr Osei to basic status on the IEP scheme. They also moved him to a different unit, still on the South site.

51. On 13 November, a substance misuse recovery coordinator, spoke to Mr Osei about his recent indication of drug use. Mr Osei denied he had taken drugs, and told the recovery coordinator that he had had stomach pain and a panic attack. The recovery coordinator told us that Mr Osei appeared genuine when he said this. She provided harm-minimisation information, and recorded that his substance misuse file would be suspended. The recovery coordinator also recorded that Mr Osei said that he did not want bereavement counselling at present and that his place on the waiting list for this had therefore been suspended.
52. On 18 November, prison staff upgraded Mr Osei to standard status on the IEP scheme.
53. On 10 December, a prisoner told Officer A that his television had been stolen from his cell. Officer A identified from CCTV recordings that Mr Osei had removed the television and taken it to the cell of a different prisoner. She challenged Mr Osei, and told us that he “acknowledged that it had to be done”. Officer A told us that the incident might have meant that Mr Osei was paying off a debt he had accrued but said she did not ask him about this at the time. She charged Mr Osei with an offence against prison discipline.
54. On 12 December, an officer recorded that he had seen Mr Osei trying to open other prisoners’ cell doors when they were at work. The officer told us that he challenged Mr Osei, and that Mr Osei just smiled back at him. He told us that his assumption at the time was that Mr Osei was trying to get into the cells to steal something. The officer submitted a security intelligence report, which the security department passed to the unit manager to challenge Mr Osei further.
55. The unit manager subsequently spoke to Mr Osei. He did not make a record of the conversation so we do not know when it took place. The unit manager said that Mr Osei referred to the incident in which he took a television from a cell, and said that he had simply borrowed it. Mr Osei also told the unit manager that he was not trying to get into other prisoners’ cells but was instead looking for his friends so he could speak to them. The unit manager told us that he had seen no evidence that would cause him to disbelieve Mr Osei or indicate that he was in debt. He took no further action.
56. From 19 to 21 December, Mr Osei spoke to his partner several times by telephone. Prisoners’ telephone calls are recorded and we listened to recordings of Mr Osei’s calls. On 19 December, Mr Osei told his partner that it was “madness” on his current wing. His partner told him that he sounded as though he was currently under the influence of drugs.
57. On 20 December, Mr Osei’s partner said that she did not trust him and that she was upset with him about many things. On 21 December, Mr Osei’s partner asked him to stop calling her.

23 December 2019

58. On the morning of 23 December, two operational managers completed the daily governor’s round (whereby a senior manager visits one unit per day in rotation and speaks to every prisoner on that unit). One of the operational managers

spoke to Mr Osei. He told us that he knew Mr Osei, having spoken to him on other units, and that they discussed his Open University course and how he was getting on. The operational manager said that he was okay and getting on with his course but that he did not like Unit 4, where he lived at the time, because there were more young men there than in his previous unit. The operational manager said that Mr Osei engaged well and there was nothing out of the ordinary in the discussion.

59. At lunchtime, a prisoner went to Mr Osei's cell. The prisoner told us that he usually called on Mr Osei at lunchtime but that day, Mr Osei appeared to have just woken up and said that he was not having lunch.
60. At around 12.24pm, an officer locked Mr Osei's door for the lunchtime period.
61. At around 1.57pm, Officer B unlocked cells on Mr Osei's landing. Local policy requires staff to check on the wellbeing and safety of prisoners at afternoon unlock, but Officer B just unlocked the cells without looking in or speaking to the prisoners.
62. At around 2.23pm, an officer went to Mr Osei's cell, having seen that the door was ajar. She looked into the cell and saw Mr Osei hanging from a ligature made from a bed sheet which he had tied to the window bars. The officer shouted to her colleagues for assistance and radioed a medical emergency code blue, indicating a life-threatening situation. The control room operator telephoned for an ambulance immediately.
63. A prisoner went to the cell and supported Mr Osei while the officer cut the ligature. The prisoner told us that he began cardiopulmonary resuscitation (CPR) for a few seconds before being relieved by prison staff who arrived at the cell. A Supervising Officer (SO) then began CPR in rotation with several other staff. They attached a defibrillator which advised not to apply a shock and to continue chest compressions.
64. At around 2.28pm, two nurses arrived and took charge of the resuscitation attempts, while prison officers continued to rotate CPR. Paramedics arrived at Highpoint at around 2.42pm. They initially continued resuscitation efforts but at around 3.30pm, confirmed that Mr Osei had died.
65. Mr Osei left a note in his cell in which he wrote that his actions were not a cry for help but that he had had enough of the "everyday struggle".

Contact with Mr Osei's family

66. Two prison family liaison officers set out to visit Mr Osei's sister on the evening of 23 December. During the journey, the police told them that the address they held for her was incorrect. One of the family liaison officers then telephoned Mr Osei's sister and explained that he needed to speak to her urgently but that he did not have her correct address. Mr Osei's sister explained that she had already heard of her brother's death as a prisoner had contacted her other brother (seemingly using an illicit mobile phone).
67. Highpoint contributed to the costs of Mr Osei's funeral in line with Prison Service instructions.

Support for prisoners and staff

68. After Mr Osei's death, a CM debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
69. The prison posted notices informing other prisoners of Mr Osei's death and offering support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Osei's death. The prisoner who helped with CPR said that staff spoke to him individually, and that he was given the opportunity to access other support services.

Post-mortem report

70. A post-mortem examination identified the cause of death as suspension by ligature (hanging). The toxicology examination did not identify any illicit drugs or alcohol, although the toxicologist noted that the blood sample was insufficient to test for synthetic cannabinoids (PS).

Findings

Identifying the risk of suicide and self-harm

71. Prison Service Instruction (PSI) 64/2011, which governs ACCT suicide and self-harm prevention procedures, requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures. We have considered whether staff at Highpoint should have recognised Mr Osei as at risk and begun ACCT procedures to support him.
72. Mr Osei had some risk factors for suicide and self-harm. There is evidence that he used PS in prison, and there are concerns that these substances may increase the risk of suicide and self-harm. As we discuss below, there is also evidence that Mr Osei might have been in debt or being bullied. Mr Osei had been prescribed antidepressant medication for many years. He had also had a recent bereavement. In the days before his death, Mr Osei had some difficult conversations with his partner, although this was not known to prison staff at the time.
73. While Mr Osei had these risk factors, and we have some concerns about the management of his antisocial behaviour, we are satisfied that there was little to indicate to staff that he was at immediate risk of suicide or self-harm at the time of his death. If prison staff had managed Mr Osei under ACCT procedures at the time of his death, it is unlikely that monitoring levels would have been sufficiently frequent to prevent his suicide, if he had planned it. We therefore consider that it would have been difficult for staff at Highpoint to have predicted or prevented his actions.

Antisocial behaviour

74. Around two weeks before his death, prison staff twice identified that Mr Osei was engaged in antisocial behaviour. Officer A, who spoke to Mr Osei about the television he took from another prisoner's cell, identified that this incident might have indicated that he was in debt but did not ask him about this. We are concerned by Officer A's comments to us that it is "normal [on Unit 4] that prisoners who keep themselves to themselves do random things every now and again" and that there is a culture of bullying on the unit.
75. The unit manager spoke to Mr Osei when he was later identified as attempting to enter other prisoners' cells. He did not record the conversation, and told us that he took no further action on the basis that – despite these two incidents and Mr Osei's unlikely explanations for them – there was no evidence that he was in debt.
76. Highpoint has a local violence reduction policy which states that they will identify and support those who are victims of violence. This should include those who are under threat of violence due to bullying or debt. The policy states that all violent incidents will be investigated within 72 hours, identifying and recording causes, risks and recommendations.

77. We are not satisfied that the incidents involving Mr Osei were appropriately investigated or recorded, and are particularly concerned that there was an apparent acceptance among some staff that antisocial behaviour on Unit 4 was a common feature of prison life. We make the following recommendation:

The Governor should ensure that all information indicating violence, bullying and intimidation is fully coordinated and investigated and that apparent victims are effectively supported and protected.

Staff-prisoner relationships

78. Highpoint's local violence reduction policy also states that a priority in reducing violence is to promote and deliver the keyworker role. Under the Offender Management in Custody model each prison officer is the named key worker for five or six prisoners and should be allocated an average of 45 minutes per week to spend on key work duties with each prisoner, including having regular meaningful conversations with each prisoner. During his year at Highpoint, Mr Osei had just one recorded keyworker session.
79. Officer C was Mr Osei's keyworker when he died but he did not see Mr Osei for a keywork session at any time. Officer C told us that he did not know how long he had been Mr Osei's keyworker. He said that he had not completed a keywork session for any prisoner for some time. Officer C said that due to staffing levels at Highpoint, staff were rarely allocated keyworker duty on their rota.
80. Keyworkers at Highpoint work on different units to their allocated prisoners. This means that they have little opportunity to have even informal conversations with their prisoners. While we appreciate the pressures that prisons are under, we consider the keyworker role to be vital in helping to ensure meaningful engagement between staff and prisoners, and identifying any underlying issues a prisoner might have. If Mr Osei's key worker had spoken to him regularly, for example, he might have been aware that Mr Osei was in debt or having difficulties with his partner. We make the following recommendation:

The Governor should ensure that there is an effective keyworker scheme which provides meaningful and ongoing support to prisoners, in line with national policy.

Unlock procedures

81. When officers unlock cells, they should take active steps to check on a prisoner's wellbeing. Local instructions at Highpoint require staff to check the wellbeing and safety of prisoners at afternoon unlock.
82. Officer B unlocked Mr Osei's cell at around 1.57pm on 23 December. He did not check on Mr Osei's wellbeing (nor that of any other prisoners on the landing). Officer B told us that he was not aware of the requirement to check prisoners' wellbeing at unlock, and that standard practice among staff on Unit 4 – as well as other units he had worked on – was to unlock cells without a welfare check.
83. An officer found Mr Osei hanged in his cell around 26 minutes after Officer B had unlocked it. We cannot say whether Mr Osei's death could have been prevented

if he had been checked earlier, but he would have been found earlier which might have altered the outcome.

84. After Mr Osei's death, the Governor reissued local instructions (*Communication to Colleagues: checking the wellbeing of residents at unlock*), reminding staff of the need to obtain a response from prisoners when unlocking cells. Officer B also told us that he has been spoken to about his responsibilities at unlock. We therefore make no further recommendation about this issue.

The Governor should ensure that a copy of this report is shared with the unit manager, Officer A, Officer B and Officer C and that a senior manager discusses the Ombudsman's findings with them.

**Prisons &
Probation**

Ombudsman
Independent Investigations