

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Nathan Pennock a prisoner at HMP Humber on 21 December 2018

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*



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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.

I carry out investigations to understand what happened and identify how the organisations whose actions I oversee can improve their work in the future.

Mr Nathan Pennock died on 21 December 2018, after being found hanged in his cell at HMP Humber. He was 30 years old. I offer my condolences to Mr Pennock's family and friends.

Mr Pennock had been recalled to prison five weeks before his death. He had given staff no indication of any thoughts of suicide during that time and we cannot say why he took his life. Toxicology tests showed that he had used a psychoactive substance (PS) before his death and this may have led him to have suicidal thoughts. However, I am concerned that there is no evidence that staff had any meaningful engagement with Mr Pennock and that this was a missed opportunity to identify his risk factors for suicide and self-harm

I also concerned about the apparent ready availability of illicit drugs at Humber.

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

November 2020

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Summary

Events

1. Mr Nathan Pennock was serving a sentence for grievous bodily harm and was in prison from November 2014 until July 2017, when he was released on licence from HMP Wymott. He had a history of illicit drug use and had suffered from depression. While in custody, Mr Pennock regularly used psychoactive substances (PS) and he was managed under Prison Service suicide and self-harm monitoring procedures (known as ACCT) on a number of occasions.
2. On 12 October 2018, Mr Pennock's licence was revoked after it was reported that he had committed further offences. Mr Pennock evaded arrest until 19 November, when he was charged with burglary, criminal damage and harassment. He was returned to custody at HMP Hull. On 4 December, Mr Pennock transferred to HMP Humber.
3. On 17 December, Humberside Police attempted to interview Mr Pennock at Humber about an alleged offence of harassment against his former partner. Mr Pennock refused to be interviewed without a solicitor present. The police arranged to return to the prison in January 2019.
4. On 21 December, at 6.03am, staff found Mr Pennock hanged in his cell. Staff requested an ambulance. A nurse responded but did not start cardiopulmonary resuscitation as it was clear Mr Pennock was dead. Paramedics arrived at 6.30am and pronounced Mr Pennock dead.

Findings

Assessment of risk

5. Mr Pennock had given no indication to staff that he had thoughts of suicide and we cannot know why he took his life. He had used PS before his death and this may have led him to have suicidal thoughts.
6. However, Mr Pennock had some risk factors for suicide and self-harm, including a history of self-harm in custody and the fact that he had been recalled to prison. There is no evidence that anyone had a meaningful conversation with him in the five weeks before his death and this may have been a missed opportunity to identify his risk factors.

Psychoactive Substances (PS)

7. Mr Pennock had a history of using PS in prison prior to his release on licence in July 2017. There was no intelligence that Mr Pennock was involved in the use of drugs, was in debt or being bullied after his recall to prison. However, toxicology tests showed that he had used a psychoactive substance (PS) immediately before his death.
8. We are concerned at the availability of PS at Humber. Although Humber has comprehensive policies to reduce substance misuse, Mr Pennock was still able access drugs. It is clear that more needs to be done to limit supply and demand.

Clinical care

9. The clinical review concluded that the healthcare provided to Mr Pennock was equivalent to that which he could have expected to receive in the community. Although Mr Pennock refused to be assessed by mental health staff, there was no evidence that he had any significant mental health problems. Mr Pennock also refused any intervention from substance misuse services.

Recommendations

- The Governor of Humber should ensure that staff have meaningful interaction with the prisoners in their care, and that the newly-implemented key worker scheme promotes early contact with prisoners.
- The Governor should ensure that the key drug issues at Humber are identified and that the prison's local drugs strategy is revised by September 2019 to ensure that these key issues are being addressed.

The Investigation Process

10. 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.
11. He visited Humber on 3 January 2019. He obtained copies of relevant extracts from Mr Pennock's prison and medical records.
12. NHS England commissioned an Independent clinical reviewer to review Mr Pennock's clinical care at the prison.
13. The investigator interviewed nine members of staff at Humber in February eight jointly with the clinical reviewer.
14. We informed HM Coroner for East Riding and Kingston upon Hull of the investigation. He gave us the results of the post-mortem examination and toxicology results. We have sent the coroner a copy of this report.
15. The Ombudsman's family liaison officer contacted Mr Pennock's family to explain the investigation and to ask whether there were any matters they wanted the investigation to consider. Mr Pennock's family wanted to know why Mr Pennock was allowed to have cord in his trousers and whether he knew what date he would be released. Mr Pennock family's questions have been answered in this report.
16. Mr Pennock's family received a copy of the initial report. They did not make any comments.
17. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly. The action plan has been annexed to this report.

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. There are healthcare staff on duty at all times.
19. In August 2018, HMP Humber was selected to be part of the '10 Prisons Project', which seeks to improve safety, security and decency in the prisons involved. The project is focussing on reducing violence, improving living conditions, preventing drugs entering the establishments and enhancing the leadership and training available to staff.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Humber was carried out in December 2017. Inspectors reported that nearly two thirds of prisoners said that it was easy to obtain drugs at Humber, and nearly a third said that they had developed a drug problem while at the prison. They found that the use of PS was particularly problematic at Humber, although it had reduced from earlier in the year after the prison implemented additional security measures. However, inspectors found that there was no up-to-date drugs supply action plan, and prisoners suspected of misusing drugs were often not tested.

Independent Monitoring Board

21. 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 published in May 2019, the IMB reported that the use of illicit drugs was still a major concern despite the proactive approach taken by staff to reduce the amount of drugs at Humber. The IMB reported that despite the strong emphasis on safer custody, there were still high levels of self-harm incidents.

Previous deaths at HMP Humber

22. Mr Pennock's death was the sixth self-inflicted death at Humber since January 2016. Four of these deaths took place in 2016 and one in 2017. There is evidence that in four of these previous self-inflicted deaths, illicit drugs had been used by prisoners before their deaths. There have also been four drug related deaths and two due to natural causes.
23. Since Mr Pennock's death, one prisoner has died from natural causes and there has been two further drug related deaths.

Psychoactive Substances (PS)

24. Psychoactive substances (formerly known as 'new psychoactive substances' 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 precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

25. 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 greater 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.
26. HM Prison and Probation Service (HMPPS) 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.

Assessment, Care in Custody and Teamwork (ACCT)

27. 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 carried out at irregular intervals to prevent the prisoner anticipating when they will occur. Regular multidisciplinary review meetings involving the prisoner should be held.
28. As part of the process, a caremap (a 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, *Management of prisons at risk of harm to self, to others and from others (Safer Custody)*.

Key Events

29. In November 2014, Mr Nathan Pennock was convicted of grievous bodily harm and was sentenced to five years six months imprisonment. His sentence was due to expire on 3 May 2020.
30. Mr Pennock had a history of illicit drug use while in custody. He was also prescribed medication for depression.
31. He was managed under suicide and self-harm monitoring procedures (known as ACCT) on several occasions after threatening to self-harm because he was in debt, and he self-harmed on two occasions: February 2015, when he made what was described as a 'serious attempt at suicide' by cutting an artery in his arm; and June 2016, when he was taken to hospital after cutting his arm and swallowing a bag of PS which he had cut so it would burst inside him. He also self-isolated at times and deliberately engineered transfers to the segregation unit because he said he was under threat over debts.
32. On 18 July 2017, Mr Pennock was released on licence from HMP Wymott.
33. While in the community, he was prescribed mirtazapine (an antidepressant) and propranolol (for anxiety) until April 2018.
34. On 12 October 2018, Mr Pennock's licence was revoked after it was reported he had committed further offences. Mr Pennock evaded arrest until 19 November, when he was charged with burglary, criminal damage and harassment against his former partner. He was returned to custody at HMP Hull.
35. When Mr Pennock arrived at Hull, he saw a nurse in reception. Mr Pennock said that he was not prescribed any medication, had no issues with drugs or alcohol and had no thoughts of self-harm. The nurse recorded that Mr Pennock had no outward signs of any physical health problems and no signs of any mental health issues or distress.
36. An officer conducted Mr Pennock's induction interview. The officer recorded that Mr Pennock had been in custody before, that there were no concerns about self-harm or suicide and that he had no health issues. The officer recorded that Mr Pennock was to be allocated a single cell as the cell sharing risk assessment (CSRA) indicated that he presented a high risk of violence to others (after threats to take a hostage from his previous time in custody).
37. On 20 November, a nurse saw Mr Pennock for a second health screen. Mr Pennock said he felt fit and well. He said he suffered from post-traumatic stress disorder (PTSD) but refused to see the mental health team. Mr Pennock also refused to be referred for smoking cessation advice and declined sexual health, hepatitis and meningitis screening.
38. On 22 November, Mr Pennock was placed on a disciplinary charge for damaging the kettle in his cell.
39. On 28 November, an officer introduced himself to Mr Pennock as his key worker and explained the key worker scheme to him. Mr Pennock said he was in prison following a recall and that he had been at Hull before and knew how things

- worked there. The officer asked him why he had damaged his kettle and Mr Pennock said he had re-wired it in order to cook in it. The officer told him that he would not get another kettle until he had either paid for it or until his ban ended at the end of December.
40. On 4 December, Mr Pennock was transferred to HMP Humber. The nurse who saw him when he left Hull recorded that Mr Pennock had no health issues, had not been prescribed any medication and had no thoughts of self-harm.
 41. When Mr Pennock arrived at HMP Humber he saw a nurse in reception. Mr Pennock said he had no health problems and denied having any thoughts of suicide or self-harm. The nurse recorded that Mr Pennock was not prescribed any medication and that he showed no signs of any mental health problems or distress.
 42. An officer conducted Mr Pennock's induction interview. Mr Pennock said he was happy to be at Humber and had no health issues. Mr Pennock said he thought he might have trouble with some prisoners at Humber but would not give any names. The officer recorded that Mr Pennock was allocated a single cell as indicated in the CSRA.
 43. The officer told the investigator that as Mr Pennock would not provide the names of any prisoners he might have problems with, he was unable to check whether these individuals were actually in custody, let alone at Humber. The officer said Mr Pennock appeared fine and he had no concerns about his wellbeing.
 44. On 6 December, Mr Pennock was seen by a chaplain as part of the induction process. There are no further entries in his prison record.
 45. On 17 December, two officers from Humberside Police visited Humber to interview Mr Pennock about his recent offences, including alleged harassment of his former partner. Mr Pennock refused to be interviewed without a solicitor present. The police arranged to return in January 2019.
 46. Mr Pennock's prison telephone records show that he was in contact with his next of kin. The investigator listened to the last three calls Mr Pennock made. Mr Pennock called his next of kin twice on 17 December. They talked about the police visit, his refusal to be interviewed and the fact that his solicitor had been killed in a car crash. Mr Pennock asked his grandmother to contact the solicitor's office and asked for £20 for "bacca". He said he was looking forward to getting out.
 47. Mr Pennock's last telephone call, which was made on 18 December, only lasted 45 seconds. He said he was due in court the next day and asked for another £20 for "bacca". The call ended abruptly at this point when Mr Pennock's phone credit ran out. (Mr Pennock's prison records show that he did not have a court appearance listed for 19 December.)

21 December 2018

48. At 6.03am on 21 December, an operational support grade (OSG), arrived at Mr Pennock's cell in the course of the early morning roll check (a security check to confirm all prisoners are in their cells). The OSG looked through the observation panel in the cell door and saw Mr Pennock hanging from the bed frame with a ligature made from a cord. The OSG immediately radioed a code blue emergency, which indicates a prisoner is not breathing or having difficulty breathing. An ambulance was called immediately.
49. Two officers arrived in under 60 seconds. They entered the cell, cut the ligature and lowered Mr Pennock to the floor. A nurse arrived but did not start cardiopulmonary resuscitation (CPR). The nurse told the investigator that he did not start CPR as rigor mortis was clearly evident, which indicated that Mr Pennock had been dead for some time, and that to start CPR would have been futile and undignified.
50. Paramedics arrived at 6.14am and at 6.30am, they pronounced Mr Pennock dead.

Post-mortem report

51. A post-mortem examination, conducted by a Home Office Forensic Pathologist, confirmed that the cause of Mr Pennock's death was hanging.
52. Toxicology tests showed that Mr Pennock had taken 4F-MDMB-BINACA (a synthetic cannabinoid, a form of PS) before his death. Dr Parsons commented that synthetic cannabinoid use may potentially lead to suicidal thinking and self-harm behaviours, among many other psychiatric symptoms.

Contact with Mr Pennock's family

53. On 21 December, at 10.00am, the Deputy Governor and family liaison officer, visited Mr Pennock's next of kin, his grandmother, at her home address. They broke the news of her grandson's death and offered their condolences. In the days that followed, Humber maintained contact with Mr Pennock's next of kin and, in line with Prison Service instructions, the prison contributed to the costs of the funeral.

Support for prisoners and staff

54. The Deputy Governor held a debrief for staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and for managers to offer support. The staff care team also offered support.
55. The prison posted notices informing staff and prisoners of Mr Pennock'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 Pennock's death.

Findings

Assessment of risk

56. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, which sets out the Prison Service's framework for delivering safer custody procedures, lists a number of risk factors and potential triggers for suicide and self-harm.
57. Staff should interview new prisoners in reception to assess their risk of suicide or self-harm. All staff should be alert to the increased risk of self-harm or suicide posed by prisoners with these risk factors and should act appropriately to address any concerns, including opening an ACCT if necessary.
58. Mr Pennock had a number of risk factors when he returned to prison in November 2018, including recall to custody, a history of depression, previous self-harm, a history of alcohol or drug abuse, the break-up of his relationship with his partner and being charged with offences against her, and the prospect of further convictions leading to more time in prison.
59. During the five weeks between being recalled to prison and taking his own life on 21 December, Mr Pennock gave no indication to anyone at Hull or Humber that he had suicidal thoughts. In that sense, staff at Humber could not have predicted that Mr Pennock intended to take his life. In addition, Mr Pennock had used PS before his death and this can trigger suicidal thinking.
60. However, no one at either prison appears to have identified that Mr Pennock had a history of self-harm in custody or to have had a meaningful conversation with him in the five weeks after his recall. Even his key worker at Hull seems to have focussed on the fact that Mr Pennock had damaged his kettle on the one occasion when they spoke. He did not meet his key worker during his three weeks at Humber and there is no evidence of any staff engagement with him after his reception there.
61. While we recognise that the key worker scheme was not fully implemented at the time, we still consider that this was a missed opportunity to encourage Mr Pennock to discuss how he felt about his recall, the break up of his relationship and the further charges he was facing. There can be a tendency among staff to assume that prisoners who have been in prison before are 'alright' or more able to cope, but this is not necessarily the case, particularly for prisoners, like Mr Pennock, who have been recalled.
62. We recommend:

The Governor of Humber should ensure that staff have meaningful interaction with the prisoners in their care, and that the newly-implemented key worker scheme promotes early contact with prisoners.

Psychoactive Substances

63. Mr Pennock had a history of illicit drug use. His prison security records show that he was involved in the use of illicit drugs in prison before his release on licence in

July 2017, and he was also known to have had drug-related debts and to have feared for his safety at times as a result.

64. After Mr Pennock was recalled to custody on 19 November 2018, there is no intelligence or evidence that he was using PS or other drugs, or that he was in debt or being bullied.
65. However, toxicology tests show that Mr Pennock had used PS before his death. There is evidence that use of PS can damage both physical and mental health, and it is possible that the use of PS affected Mr Pennock's thinking and behaviour before his death.
66. Humber issued a revised PS action plan in April 2017 after a significant increase in PS use at the prison. This addressed both the supply of, and demand for, PS. It included actions intended to reduce the supply of drugs and the movement of drugs around the prison, including the introduction of a new radio code to alert staff when a package is suspected of being delivered into the prison or a drone is sighted; photocopying mail to prevent paper sprayed with PS entering the prison; and providing additional staff resources to carry out mandatory drugs tests and cell searches. Measures were also introduced to educate prisoners about the dangers of PS and support those known to use the drugs, with additional disciplinary measures to deter drug use.
67. Although Humber has responded proactively to the evolving challenges of PS supply and demand, HMIP and the IMB remain concerned about the availability of drugs at the prison, and we have investigated four other self-inflicted deaths before Mr Pennock's and one since in which prisoners had used illicit drugs before taking their lives. We are concerned too that Mr Pennock was seemingly able to obtain and use PS without staff becoming aware. It is clear, therefore, that more needs to be done to reduce both the supply and the demand for PS at Humber.
68. Humber is not alone in this. Drug use is a serious problem across much of the prison estate. Individual prisons are, for the most part, doing their best to tackle the problem by developing their own local drug strategies. However, the PPO has called for national guidance to be provided to prisons by HMPPS, giving evidence-based advice on what works. We welcome the fact that such guidance was issued in April 2019, together with a Prison Service strategy, to reduce the supply of, and demand for, drugs in prisons.
69. In relation to reducing the supply of drugs, the new Prison Service strategy states:

“Every prison is different, and will benefit from tools to assess their specific security needs. We have worked with prisons to carry out Vulnerability Assessments in prisons to build a picture of the security risks and enable establishments to better target their resources to tackle them. This resource will continue to be offered across the estate. The Drug Diagnostic toolkit used for the prisons in the 10 Prisons Project has also proved to be useful in identifying key issues in different establishments and so we will share this for use across the whole estate, supporting prisons to identify where changes could have the greatest impact.”

70. We, therefore, recommend:

The Governor should ensure that the key drug issues at Humber are identified and that the prison's local drugs strategy is revised by September 2019 to ensure that these key issues are being addressed.

Clinical care

71. The clinical reviewer judged that the care that Mr Pennock received from healthcare staff at Humber was equivalent to the care he would have received in the community. Mr Pennock had a previous history of depression and alcohol use, but there is no evidence that this was an issue following his recall to custody.
72. He also judged that, in line with NHS England guidelines, a nurse was correct not to start resuscitation when Mr Pennock was found hanged as rigor mortis was present.

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