

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Craig Thompson a prisoner at HMP Warren Hill on 11 May 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*



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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 Craig Thompson died on 11 May 2019, after being found hanging in his cell at HMP Warren Hill. He was 49 years old. I offer my condolences to Mr Thompson's family and friends.

Mr Thompson did not give any indication to staff or prisoners that he was at imminent risk of suicide. I am satisfied that staff could not have reasonably foreseen or prevented his actions on 11 May.

I am concerned at the delay in staff identifying that Mr Thompson was hanging and in calling a medical emergency code. When staff unlocked Mr Thompson's cell on the morning of 11 May, they could not open the door and could not see Mr Thompson through the observation panel. It was not until a prisoner looked into the cell and saw Mr Thompson hanging that staff called a medical emergency code. This was four minutes after Mr Thompson's cell was unlocked.

I cannot say whether the delay affected the outcome for Mr Thompson, but we know that in an emergency situation a delay of even a few minutes may be critical.

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

March 2020

Contents

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

Summary

Events

1. Mr Craig Thompson (formerly known as Craig Hendley) was serving a life sentence for murder. He arrived at HMP Warren Hill on 16 March 2018.
2. Mr Thompson complied with the prison regime and gave staff no cause for concern. The only issue for Mr Thompson appeared to be that he was concerned about the lack of information he had about his daughter, who was in the care of the local authority and was subject to court proceedings to enable her to be adopted. In November 2018, the court decided that Mr Thompson's daughter should be adopted.
3. On 11 May 2019, at 8.48am, an officer unlocked Mr Thompson's cell but she could not open the cell door. She looked through the observation panel but could not see Mr Thompson and when she called him, she got no response. She went to the wing office to ask for assistance and two minutes later returned with another officer. He could not see Mr Thompson either. He remained outside the cell while the other officer went back to the office to get the toilet hatch key, as they thought he might be in the toilet area of the cell.
4. At 8.51am, a prisoner looked through Mr Thompson's observation panel and saw Mr Thompson hanging from the window. An officer looked into the cell again and saw Mr Thompson hanging. At 8.52am, he radioed a medical emergency code. Officers kicked open the door, entered Mr Thompson's cell, cut the ligature and started cardiopulmonary resuscitation (CPR). At 9.19am, paramedics arrived and continued with emergency treatment. They were unable to resuscitate Mr Thompson and at 9.27am, pronounced him dead.

Findings

5. Mr Thompson gave no indication to staff or fellow prisoners that he was at imminent risk of suicide. We are satisfied that staff could not have foreseen or prevented his actions on 11 May.
6. We are concerned at the delay in identifying that Mr Thompson was hanging and in calling a medical emergency code. It is troubling that a prisoner identified that Mr Thompson was hanging when two members of staff had already looked into the cell and did not see him. This caused a delay of around four minutes in calling an ambulance. We cannot say whether this affected the outcome for Mr Thompson but we know that in an emergency situation a delay of a few minutes may be critical.
7. The records of the prison's contact with Mr Thompson's next of kin after his death were incomplete and lacked detail. They did not contain information about the contact made on 11 and 12 May, including when staff told Mr Thompson's next of kin of his death.

Recommendations

- The Governor should issue comprehensive guidance to staff on unlocking procedures so that staff are clear about what is expected of them, particularly if they cannot enter the cell and cannot get a response from the prisoner.
- The Governor should ensure that following a death in custody staff open and complete a log book to properly record all contacts with the next of kin in line with national policy.
- The Governor should ensure that a copy of this report is shared with staff named in this report.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Warren Hill informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
9. The investigator visited Warren Hill on 22 May 2019. He obtained copies of relevant extracts from Mr Thompson's prison and medical records. He also interviewed two prisoners.
10. NHS England commissioned an independent clinical reviewer to review Mr Thompson's clinical care at the prison.
11. The investigator interviewed four members of staff by videolink and telephone in May and July 2019.
12. We informed HM Coroner for Suffolk of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
13. One of the Ombudsman's family liaison officers contacted Mr Thompson's partner to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not raise any issues.
14. The prison service received a copy of the initial report. They did not make any accuracy comments. Their response to our recommendations and action plan is annexed to this report.

Background Information

HMP Warren Hill

15. HMP Warren Hill is a medium secure prison that holds nearly 258 men mostly serving life sentences and indeterminate sentences for public protection.
16. Care UK provides healthcare services. Nurses are on duty between 7.30am and 7.45pm during the week, and 7.30am to 5.30pm on weekends and public holidays. Nurses provide regular clinics for chronic conditions, substance misuse and mental health. Doctors consult at the prison from 10.45am to 1.00pm on Monday to Friday.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Warren Hill was in October 2015. Inspectors noted that excellent relationships between staff and prisoners were at the heart of all that was good at Warren Hill. There was a positive staff culture which emphasised a professional, caring but challenging approach. All prisoners, regardless of where they were located, had a personal officer or key worker, and unlike many other prisons this was a meaningful relationship, founded on decency.
18. Inspectors found that too few discipline staff were trained in first aid and that while staff had easy access to defibrillators, they were concerned that too few knew where they were or were trained to use them. Inspectors reported that levels of self-harm were low and although there were some deficiencies, suicide and self-harm prevention procedures (known as ACCT) were mostly satisfactory.

Independent Monitoring Board

19. 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 31 May 2018, the IMB reported that there was a strong focus on safety awareness. First aid training had been stepped up and staff were required to attend suicide and self-harm training. The Board noted that compared to other prisons there were few men identified as at risk of self-harm.

Previous deaths at HMP Warren Hill

20. Mr Thompson is the only prisoner to have died at Warren Hill since May 2017.

Incentives and Earned Privileges (IEP) scheme

21. Each prison has an Incentives and Earned Privileges scheme which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of reoffending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and to wear their own clothes. There are three levels, basic, standard and enhanced.

Key worker programme

22. The key worker programme – which has been in place across the prison estate since March 2019 - is designed to help reduce violence and self-harm in prisons by encouraging meaningful contact and positive relationships between officers and prisoners. As key workers, all prison officers will hold a small caseload of around six prisoners. They will meet regularly and provide supportive challenge to prisoners, to motivate them to use their time in custody to best effect. Key work builds on the foundations of Five Minute Intervention (FMI) and seeks to develop constructive, motivational relationships with individuals in prison, supporting them to make appropriate choices, giving them hope and responsibility for their own development. It is an integral part of being a prison officer and key work training is now part of prison officer entry level training.

Key Events

23. On 29 July 1992, Mr Craig Thompson was sentenced to life imprisonment for murder. (He was convicted in the name of Craig Hendley but he changed his name to Craig Thompson in 2013.) He was released on licence in August 2016 but was recalled to prison in September after breaching his licence conditions. Mr Thompson was released again in February 2017.
24. On 13 September 2017, Mr Thompson was recalled to prison because he took heroin and did not return to his hostel. He was put on a methadone programme, which he completed on 2 March 2018.

HMP Warren Hill

25. On 16 March 2018, Mr Thompson was moved to HMP Warren Hill. At his initial health screening Mr Thompson told the nurse that he did not have any thoughts of suicide or self-harm. The nurse recorded that Mr Thompson had completed a methadone detoxification programme and appeared stable. Mr Thompson told the nurse that he did not have any mental health concerns and did not want to be referred to substance misuse services. Mr Thompson was given a single cell in Oak Unit.
26. On 26 March, Mr Thompson started to work at the raptor workshop, breeding birds. Staff recorded that Mr Thompson worked six days a week, left his cell early every morning and spent most of the day at work. Staff did not raise any concerns about Mr Thompson's behaviour. He was on the enhanced level of IEP while at Warren Hill.
27. On 22 April, an officer, Mr Thompson's key worker saw Mr Thompson. Mr Thompson spoke about his child who was born in November 2017. He said that his partner went into labour when she was seven months pregnant, due to the stress of him being recalled. Mr Thompson told the officer that family relationships were difficult for him. Mr Thompson and the officer had regular contact thereafter.
28. On 4 May, Mr Thompson was taken for DNA testing to verify the paternity of his daughter. An officer recorded that a member of staff from legal services, commented that Mr Thompson was clearly passionate about his daughter and this gave him the motivation to be released and stay out of prison. The DNA test results showed Mr Thompson was the child's father.
29. An offender supervisor told the investigator that Mr Thompson's child had been a 'looked-after-child' since January 2018. This meant that a court had granted an order for a local authority to care for her and court proceedings were ongoing to decide whether she should be adopted. The offender supervisor said that social services were not relaying any information to him or Mr Thompson on the progress of the proceedings and this was a stressful situation for Mr Thompson.
30. On 4 June, staff searched Mr Thompson's cell and found a mobile phone. Mr Thompson was dismissed from his job. Mr Thompson said that he had used the phone to speak regularly with his partner about his child's case. Ten days later, the offender supervisor and the head of the offender management unit (OMU)

discussed this with Mr Thompson. They noted that Mr Thompson was low in mood. The offender supervisor contacted the local authority to see if they could provide any information about the proceedings, but they were not prepared to share any information.

31. On 23 July, Mr Thompson started work again at the raptor workshop. On 1 August, he met with his keyworker who recorded that since Mr Thompson had gone back to work he was in a better mood. The workshop instructor recorded several positive comments about Mr Thompson's behaviour at work. Mr Thompson was awarded a "red-band" at the workshop which meant that he was given more trusted responsibilities.
32. On 11 September, Mr Thompson moved to Alder Unit and told his key worker that he had been settling well in the unit. He requested the move because most of the prisoners working in the raptor workshop lived there.
33. On 16 October, Mr Thompson told the offender supervisor that he had sought support from family services to help him with his issues with his child. Mr Thompson repeated that he felt frustrated as his name did not appear on her birth certificate. On 8 November, a final hearing took place, which decided that Mr Thompson's child would be adopted.
34. On 14 December, Mr Thompson told the offender supervisor that he had been told he was going to be allocated a new key worker in Alder Unit. Mr Thompson was concerned that he had relayed personal information to his key worker and said he had provided him with meaningful support. The offender supervisor agreed it was not appropriate and emailed a manager expressing his concerns.
35. On 18 December, an officer introduced himself as Mr Thompson's new key worker. He explained to Mr Thompson that although the prison had tried to keep his previous key worker, this was not practical due to "work-area restrictions". He recorded that Mr Thompson accepted the decision and said that he understood.
36. On 25 February 2019, Mr Thompson had a sentence progression review with the offender supervisor, his offender manager and the Head of Residence and Safety. During the review, Mr Thompson said that he had had a difficult year as he felt helpless having no input into his child's life.
37. After the review meeting, the Head of Residence and Safety awarded Mr Thompson progression to stage three given his excellent behaviour and presentation. (Warren Hill operates a three-tier approach for sentence progression.) The offender supervisor told the investigator that having reached stage three was a great achievement for Mr Thompson. It meant that Mr Thompson had a full understanding of his risks, was a model citizen and was fully engaging with the regime.
38. In February, Mr Thompson stopped working at the raptor workshop and started a new job at the welding workshop. The workshop instructor told the investigator that Mr Thompson wanted a change.
39. On 15 April, the offender supervisor recorded that Mr Thompson appeared calmer and willing to engage with professionals. He recorded that Mr Thompson had managed the frustrations around his family issues well. He recorded that Mr

Thompson's child had been placed for adoption. He assessed that Mr Thompson appeared to be happy with his sentence plan and progression and did not raise any concerns. He told the investigator that he was going to recommend Mr Thompson's release at his next parole review before January 2020 and that Mr Thompson was aware of this.

40. On 23 and 26 April, his new key worker spoke to Mr Thompson. These were their last conversations before Mr Thompson killed himself. He recorded that Mr Thompson continued to do well at Warren Hill and at his new employment in the welding workshop. He explained to Mr Thompson that he was going to be away for a couple of weeks. Mr Thompson did not raise any concerns.
41. On 5 May, an officer spoke to Mr Thompson as he had not received any visits at Warren Hill and he was concerned that he was self-isolating. The officer recorded that Mr Thompson had separated from his partner and had no one else to call or visit him. Mr Thompson reassured the officer that he did not feel socially isolated and was interacting well with his peers.
42. There were no further relevant entries in Mr Thompson's prison record during the following week. Another prisoner told the investigator that during the week before Mr Thompson died, Mr Thompson was socialising with his peers normally and raised no concerns.

Events on 11 May 2019

43. On 11 May at 7.02am, an officer arrived at Mr Thompson's cell during his morning roll check. CCTV shows that the officer opened Mr Thompson's observation panel and looked through. He told the police that he saw Mr Thompson in his bed sleeping and did not note anything of concern.
44. At 8.48am, an officer unlocked Mr Thompson's cell. She tried to push the door open but it would not open enough to see inside. (Mr Thompson had blocked his door with a table.) She looked through the observation panel but could not see Mr Thompson. She told the investigator that she called his name but got no response. She went to open another cell and then returned to Mr Thompson's cell seconds later. She told the investigator that she thought Mr Thompson could have been sleeping on the floor or on a chair by the door. She looked through the observation panel again but still could not see Mr Thompson. She walked down to the ground floor (Mr Thompson's cell was on the second floor) to ask for assistance from a second officer.
45. The second officer had been unlocking cells on the same floor as Mr Thompson's cell but had gone back to the office on the ground floor when he had finished. He said the first officer arrived and told him that she could not open Mr Thompson's door and could not see anybody inside. She did not have a radio with her. The Head of Residence and Safety told the investigator that this was because she had been detailed to do key work with other prisoners that day and therefore she was not expected to have a radio. The second officer did have a radio.
46. At 8.50am, both officers returned to Mr Thompson's cell. The second officer tried unsuccessfully to open the door. He looked through the observation panel. He told the investigator that he could not see Mr Thompson. He said that he could

not remember if Mr Thompson's bed was made or not but the first officer told the investigator that she was almost certain that Mr Thompson's bed was made. CCTV footage shows that the second officer then stood by the wall and spoke to another prisoner. The first officer went back to the office to get the toilet-hatch key, as she thought Mr Thompson might be in the toilet.

47. A prisoner told the investigator that he saw an officer standing by Mr Thompson's cell door, which he thought was odd, so he went over. He said that he called Mr Thompson's name and then opened the observation panel. He said that he saw that Mr Thompson's bed was made. Then he looked up and saw that Mr Thompson was hanging in the far right-hand corner of his cell, from the window, and shouted for help.
48. The second officer looked through the observation panel again and saw Mr Thompson hanging. At 8.52am, he radioed a code blue (a code blue emergency indicates that a prisoner is unconscious or having difficulty breathing). The ambulance records show that the control room officer called an ambulance immediately.
49. The second officer then managed to kick open the door and entered the cell with another officer. He cut the ligature, which was made of bedding, and placed Mr Thompson on his bed. The first officer started cardiopulmonary resuscitation (CPR). The second officer told the investigator that Mr Thompson was very pale, and his lips were purple. He told the investigator that Mr Thompson appeared to be dead.
50. At 8.54am, an officer brought the defibrillator and two minutes later two nurses arrived. They continued with CPR. The ambulance service records show that paramedics arrived at the prison's gate at 9.17am, and at Mr Thompson's cell at 9.19am. They continued with emergency treatment but could not resuscitate Mr Thompson. At 9.27am, they pronounced him dead.
51. Mr Thompson left two notes in his cell. One was to his next of kin, in which he told her that she had failed him. The other said that all his property should be sent to his partner. It said, "Now I'm free at last and no more heartache."

Contact with Mr Thompson's family

52. On 11 May, the duty governor asked the Governor at HMP Wakefield to assist in delivering the news of Mr Thompson's death to his partner, who lived in Yorkshire. Later, an officer from Wakefield went to Mr Thompson's partner's home but she was not there. Staff waited outside the property and telephoned her but could not contact her. Staff left a note asking her to call Warren Hill.
53. That evening, Mr Thompson's partner called Warren Hill and a Custodial Manager (CM) broke the news of Mr Thompson's death to her over the phone. The next day, the duty governor spoke to her and offered support. Thereafter the Head of Residence and Safety took over as family liaison officer and continued contact with her.
54. Mr Thompson's funeral took place on 6 June. The prison contributed to the funeral costs in line with national policy.

Support for prisoners and staff

55. After Mr Thompson's death, the Governor 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.
56. The prison posted notices informing other prisoners of Mr Thompson'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 Thompson's death.

Post-mortem report

57. Two post-mortem examinations were carried out on Mr Thompson. Both examinations concluded that the cause of his death was hanging. Toxicology tests did not find any illicit drugs in Mr Thompson's body.

Findings

Identifying and assessing risk

58. Prison Service Instruction (PSI) 64/2011 on safer custody requires all staff in contact with prisoners to be aware of the triggers and risk factors that might increase a prisoner's risk of suicide and self-harm, and to take appropriate action, including starting ACCT procedures, if necessary. Mr Thompson's risk factors included his family instability, a tendency to self-isolate and occasional low mood.
59. A significant concern for Mr Thompson was his relationship with his child who had been taken into care and put up for adoption. Mr Thompson felt frustrated and hopeless at not being able to have meaningful input into the legal process that led to her adoption. Mr Thompson was very proud of his child, who he had seen only in photographs, and was his motivation to move forward.
60. We are satisfied that staff offered adequate support to Mr Thompson and took actions to help him with his concerns. His offender manager, for example, contacted social services and sought further information about Mr Thompson's child to share with him. Mr Thompson had regular interactions with his key workers. They were proactive in exploring Mr Thompson's feelings and listening to him.
61. When staff were concerned about Mr Thompson's apparent self-isolation, officers went to speak to him and checked if he was okay. This was the case during the week before he died when an officer noted that Mr Thompson had not received any visits from family or friends. This was good practice.
62. We consider that Mr Thompson did not give any indication to staff that he was at imminent risk of suicide. All the members of staff and prisoners we spoke to said that this outcome was totally unexpected. We do not consider that staff could have reasonably foreseen or prevented Mr Thompson's actions on 11 May.

Emergency Response

63. We are concerned at the delay in identifying that Mr Thompson was hanging and in calling a code blue emergency. CCTV footage shows that two officers looked through the observation panel on at least four occasions - spending on average five seconds per observation - but they said they could not see Mr Thompson.
64. An officer told the investigator that Mr Thompson was wearing a blue t-shirt which was of a similar colour to the curtains. Mr Thompson's legs were behind his bed so only the top part of his body was exposed. She said that Mr Thompson's face and arms were difficult to identify and for that reason she could not see him. We note her comments, but it took a prisoner only one observation of around eight seconds, to realise that Mr Thompson was hanging. Given that officers could not see where Mr Thompson was, could not open the cell door and could not get a response from him, we consider that they should have spent longer looking into the cell than they did, as there was clearly something wrong.
65. CCTV footage shows that the second officer stood by the wall for about a minute while he waited for the first officer's return with the toilet-hatch key. It was at this

point that a prisoner looked into the cell and saw Mr Thompson hanging. We consider that the situation was so worrying at that point, that the second officer should have been more proactive and should have continued checking on Mr Thompson's cell.

66. As a result of these missed opportunities, there was a delay of about four minutes before an ambulance was called. This could have been longer if it was not for a prisoner's actions. We cannot say whether the delay made a difference in Mr Thompson's case but we know that in an emergency situation, a delay of a few minutes may be critical.
67. A notice to staff issued by Warren Hill in 2016, says that it is of paramount importance that staff ensure the immediate wellbeing of the prisoner during unlock procedures. Staff are required to ensure themselves that there are no immediate issues that need attention. We consider that both officers' did not fully satisfy this expectation.
68. The notice however is three years old and is not comprehensive. We consider that the prison should issue updated guidance on unlock procedures so that staff are clear about what is expected and the procedures they should follow if they cannot get a response from a prisoner. We make the following recommendation:

The Governor should issue comprehensive guidance to staff on unlocking procedures so that staff are clear on what is expected of them, particularly if they cannot enter the cell and cannot obtain a response from the prisoner.

Clinical Care

69. Although Mr Thompson had some historic mental health issues, he did not need any input from the mental health team in the 12 months before his death. No concerns were raised about his mental health at Warren Hill by prison or healthcare staff, or by Mr Thompson himself.
70. The clinical reviewer found that the healthcare provided to Mr Thompson was of a good standard and was at least equivalent to that he could have expected to receive in the community.

Contact with family

71. PSI 64/2011 says that a log book recording contact with the next of kin must be opened when there is contact with the family. Every contact with the family and their representatives should be recorded wherever possible. Log entries need to be an accurate record and should be written up as soon as possible after contact is made.
72. The PSI says that as a minimum, logs should contain the following information:
 - dates and times of all contacts/meetings;
 - method of contact and venue;
 - details of who initiated the contact;
 - details of the purpose of the contact and any information exchanged;
 - details of any non-family members present at the meeting;

- what the family liaison officer has told the family;
- every request, question or complaint that the family makes and follow up action;
- strategy agreed with supervisor and any agreed changes;
- tactical decisions, for example, about the delay or withholding of information and the reason; and,
- attempts to contact the family or their representatives, including those without success or which were refused or declined, and any reasons given.

73. The records of contact with the family after Mr Thompson's death were incomplete and lacked detail. Crucially, the prison did not make any record of a CM and the duty governor's contacts on 11 and 12 May when they told Mr Thompson's partner of his death. We make the following recommendation:

The Governor should ensure that following a death in custody staff open and complete a log book to properly record all contacts with the next of kin in line with national policy.

Sharing our report with staff

74. We consider that staff who were involved in Mr Thompson's care should see the findings of our investigation and therefore we make the following recommendation:

The Governor should ensure that a copy of this report is shared with staff named in this report.

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