

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Clinton Sentance, a prisoner at HMP Gartree, on 26 February 2020

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 Clinton Sentance died on 26 February 2020 at HMP Gartree, having been found hanging in his cell. He was 40 years old. I offer my condolences to Mr Sentance's family and friends.

Our investigation found a number of failings in Mr Sentance's care at Gartree.

I am concerned that Mr Sentance felt under threat, but there is no evidence that his concerns were investigated. I am also concerned that there is very little evidence of any meaningful staff interaction with him, which could have been a missed opportunity to identify his concerns and assess his risk to himself.

On the night that Mr Sentance died, he had blocked his cell observation panel. Staff did not ensure that he unblocked the obstruction for over 10 hours, even when they were unable to obtain a response from him, contrary to national instructions. We cannot say if this affected the outcome for Mr Sentance, but at the very least he would have been found earlier.

I am also concerned that the prison's liaison with the PPO was poor: the investigator had difficulty in getting access to witnesses for interview and some of our requests for evidence were not responded to. I regret that this has caused a delay in producing this report and I apologise for the additional distress this is likely to have caused Mr Sentance's family.

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

October 2021

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Summary

Events

1. In June 2017, Mr Clinton Sentance was sentenced to life imprisonment. In April 2019, Mr Sentance transferred to HMP Gartree.
2. Mr Sentance had a history of drug misuse. He told staff that he had stopped using drugs apart from when he was stressed.
3. In January 2020, staff found Mr Sentance under the influence of an illicit substance. Subsequent tests showed that he had taken synthetic cannabinoids (psychoactive substances (PS)). Mr Sentance was referred to the substance misuse team, but at his appointment he became angry and said that he did not need drug services. He failed a drug test in February.
4. On 12 February, Mr Sentance thought he heard some prisoners say that he was going to be assaulted. Staff referred Mr Sentance to the Challenge, Support and Intervention Planning (CSIP) programme, but there is no evidence that staff investigated the allegation or took any action before closing the supportive measure a few days later.
5. When the night officer on Mr Sentance's wing came on duty on the evening of 25 February, Mr Sentance's cell door observation panel was blocked. The night officer said he told Mr Sentance to remove the obstruction at about 8.30pm. When the officer checked again at 5.44am, the panel was still blocked, and Mr Sentance did not answer the officer. Despite another officer coming to the wing, no one contacted the night orderly officer (in charge of the running of the prison) until 6.48am.
6. When the night orderly officer and other colleagues eventually opened Mr Sentance's cell door, they found Mr Sentance hanging. They lowered him to the bed and called an ambulance. A nurse arrived and attempted to revive Mr Sentance until paramedics arrived and, at 7.20am, confirmed that he had died.

Findings

Blocked observation panels

7. When the night officer found Mr Sentance's observation panel blocked, he did not follow local policy and inform the night orderly officer immediately. When he told a colleague, that officer also failed to follow the local policy. As a result, Mr Sentance's panel was blocked for over 10 hours before he was found hanging.
8. The night officer also contravened national instructions by reporting the roll check as correct twice, even though he had not seen Mr Sentance.
9. We cannot say whether the outcome might have been different for Mr Sentance if he had been found earlier.
10. We consider that the Governor will want to look into the events of 25/26 February further, with a view to considering whether disciplinary action against the two members of staff is appropriate.

Key Worker Scheme

11. The purpose of the key worker scheme is to give each prisoner a point of contact who will meet them regularly to help and support them. Mr Sentance's prison record shows no key worker entries during the 11 months he spent at Gartree. There is little evidence of staff having any meaningful interaction with Mr Sentance.

Allegations of bullying

12. Although Mr Sentance told staff that he was worried about being assaulted because of his offences, there is no evidence that staff took any action to investigate his claim or protect him. This was another missed opportunity to support Mr Sentance.

Substance misuse

13. Mr Sentance had a history of substance misuse. He failed drug tests but declined to engage with the substance misuse team. Intelligence after his death suggested that Mr Sentance had been using drugs and had incurred debts as a result. We are concerned that staff were not aware of the extent of Mr Sentance's drug use.

Mr Sentance's healthcare

14. Mr Sentance had no physical health problems. He was offered appropriate support from substance misuse services. The clinical reviewer concluded that the care he received was at least equivalent to that which he could have expected in the wider community.

Liaison with the PPO

15. The PPO had difficulty engaging with liaison staff in Gartree on occasions and in obtaining evidence. This delayed the production of this report.

Recommendations

- The Governor should commission an investigation into the failure to follow policy when Mr Sentance blocked his cell observation panel, with a view to considering whether disciplinary action is warranted for OSG A or Officer A.
- The Governor should ensure there are robust management checks to ensure that roll checks are carried out in line with guidance.
- The Governor should remind night staff of the correct procedures when an observation panel is blocked.
- The Governor should ensure that staff have meaningful interaction with the prisoners in their care, and that the key worker scheme promotes early and regular contact with prisoners.

- The Governor should satisfy himself that procedures to address allegations of bullying are sufficiently robust, and that appropriate support is offered to victims.
- The Governor should ensure that the key drug issues are identified, that the local drugs strategy addresses these key issues, and that staff remain vigilant to signs that a prisoner is involved in drug use or supply.
- The Governor should ensure that all evidence relevant to a death in custody is retained and that evidence is made available to the PPO, in line with PSI 58/2010.

The Investigation Process

16. The investigator issued notices to staff and prisoners at HMP Gartree informing them of the investigation and asking anyone with relevant information to contact him.
17. The investigator contacted Gartree and obtained copies of relevant extracts from Mr Sentance's prison and medical records.
18. The investigator interviewed three members of staff at Gartree. NHS England commissioned a clinical reviewer to review Mr Sentance's clinical care at the prison.
19. There were delays in HMP Gartree responding to requests from the investigator, which unfortunately led to a delay in publishing our report. We have written to the Governor to express our concerns.
20. We informed HM Coroner for Leicester City and South Leicestershire of the investigation. She gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
21. One of the Ombudsman's family liaison officers contacted Mr Sentance's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Sentance's mother did not raise any specific issues.

Background Information

HMP Gartree

22. HMP Gartree, which is near Market Harborough in Leicestershire, holds up to 700 men mainly sentenced to life imprisonment and other indeterminate sentences. Nottinghamshire Healthcare Foundation Trust provides healthcare until November 2018. Nursing staff are available 24 hours a day.

HM Inspectorate of Prisons

23. The most recent inspection of HMP Gartree was a scrutiny visit in September 2020. Inspectors reported that levels of self-harm had increased. Relations between staff and prisoners were good and most prisoners received key work sessions. Challenge, Support and Intervention Planning (CSIP) was widely used but most plans were too basic and support for victims was underdeveloped. Care for vulnerable prisoners was reasonably good.
24. The last full inspection was an unannounced visit in November 2017. Inspectors commented on the easy availability of drugs. They said that the prison's response to drug issues needed to be much better.

Independent Monitoring Board

25. 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 November 2019, the IMB reported that illegal drugs continued to infiltrate the prison, and this was linked to debt, violence and bullying. Work needed to be done to train and promote wider knowledge of the CSIP process among staff and prisoners. The report also mentioned a high level of incorrect roll calls. The Board also noted that deficiencies in staffing arrangements were affecting the key worker scheme.

Previous deaths at HMP Gartree

26. Mr Sentance was the fourth Gartree prisoner to die since the beginning of 2018. Two of the previous deaths were due to natural causes and one was self-inflicted. There have since been a further five deaths from natural causes (including one due to COVID-19). We have previously made recommendations around Gartree's response to drug supply and demand.

Challenge, Support and Intervention Planning (CSIP)

27. CSIP is a multi-disciplinary approach which focuses on those prisoners who pose a raised risk of violence, as well as supporting those who are potential victims of violence. It is centred on the needs of the individual, providing them with the appropriate support.

Incentives and Earned Privileges (IEP) Scheme

28. 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 re-offending, 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.

Psychoactive substances (PS)

29. Psychoactive substances, previously known as 'legal highs' are an increasing problem across the prison estate. They are difficult to detect. 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.
30. In July 2015, we published a Learning Lessons Bulletin about the use of PS 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.

The key worker scheme

31. The key worker scheme is a key part of HMPPS's response to self-inflicted deaths, self-harm and violence in prisons. It is intended to improve safety by building better relationships between staff and prisoners and helping prisoners settle into life in prison. HMPPS's *Manage the Custodial Sentence Policy Framework* says:
 - All prisoners in the male closed estate must be allocated a key worker whose responsibility is to engage, motivate and support them through the custodial period.
 - Governors in the male closed estate must ensure that time is made available for an average of 45 minutes per prisoner per week for delivery of the key worker role, which includes individual time with each prisoner.
 - Within this allocated time, key workers can vary individual sessions in order to provide a responsive service, reflecting individual need and stage in the sentence. A key worker session can consist of a structured interview or a range of activities such as attending an ACCT review, meeting family during a visit or engaging in conversation during an activity to build relationships.

Key Events

32. In March 2017, Mr Clinton Sentance was charged with aggravated burglary and robbery. He was convicted in June 2017 and sentenced to life imprisonment.
33. Mr Sentance had a history of depression and drug misuse. He said he had only self-harmed once, many years previously. When he was convicted, staff were concerned at his low mood and began to manage him under Prison Service procedures for those at risk of self-harm (known as ACCT). He remained under ACCT management for five days. He was referred to the mental health team, but in August asked to be discharged from their services.
34. Shortly before he went to prison, two of his sisters had died within days of each other. In May 2018 he told his offender supervisor that he had used substances on the anniversaries of his sisters' deaths in December and their funerals in February, but otherwise did not use drugs in prison. When he transferred to Lincoln in January 2019, the trigger dates of the anniversaries of his sisters' deaths and funerals were noted.

HMP Gartree

35. On 5 April 2019, Mr Sentance transferred to HMP Gartree. In Lincoln, he had been held in the vulnerable prisoner unit (VPU) as there had been local media coverage of his offences, which put him at greater risk of violence from other prisoners. Gartree does not have a VPU, and Mr Sentance was allocated a single cell on a standard wing. He had reception and induction interviews and was told what support was available, including from the drug and alcohol substance treatment and rehabilitation team (START).
36. On 3 June, Mr Sentance applied to join Gartree's therapeutic community. He said that he had stopped using drugs but reverted to them in times of serious stress (such as a family bereavement). He wanted to work on this. At a categorisation review on 20 June, Mr Sentance said that he only needed drugs around the time of his sisters' anniversaries, something he did not feel that he had dealt with. He was not currently working with substance misuse services but was willing to do so if it was part of his sentence plan.
37. There are no meaningful entries from Mr Sentance's key worker or any other officer in his electronic prisoner record throughout his time at Gartree.
38. In November, Mr Sentance was found in possession of fermenting liquid (hooch). He was downgraded to the basic level of the IEP scheme. Mr Sentance referred himself to substance misuse services. On 29 November, he told a member of the START team that he had been forced to hold the hooch. He said he did not drink and would not want to jeopardise his progression as he wanted to move off his current wing. He said that he had no issues with alcohol and no need to engage further with substance misuse services.

2020

39. On 31 January 2020, staff found Mr Sentance under the influence of an illicit substance. A code blue emergency was called (meaning a prisoner is

unconscious or having difficulty breathing). Healthcare staff provided medical aid until Mr Sentance became violent, and they had to withdraw. He was subsequently given a drug test, which showed that he had taken synthetic cannabinoids (a type of PS). Mr Sentance was moved to the segregation unit and referred to the substance misuse team. On 3 February, a START worker explained to him that he had been referred to START because he had been using drugs. Mr Sentance became annoyed and said that he did not need to engage with drug services.

40. On 11 February, Mr Sentance was given a mandatory drug test. Results subsequently showed the presence of PS, so staff planned to test him regularly for drugs over three months to monitor the extent of his drug use.
41. On 12 February, Mr Sentance said he thought he had overheard some prisoners saying that he was going to be assaulted. He told staff that he did not know the prisoners but was concerned that it might be related to his offences. Staff referred Mr Sentance to the Challenge, Support and Intervention Planning (CSIP) programme, which should have meant fast-track access to the mental health team and the substance misuse team if necessary. Officers also submitted an intelligence report and made a note in the observation book to alert other staff. There was no entry in Mr Sentance's electronic record about contact with, or support from, a key worker.
42. On 18 February, a Supervising Officer (SO) completed Mr Sentance's CSIP form. He concluded that there had been no further incidents, and there was no need for any further CSIP action.
43. On 19 February, Mr Sentance attended a disciplinary hearing in relation to his drug test on 11 February. Mr Sentance had 50% of his earnings stopped for 14 days, and had certain privileges withdrawn.

25/26 February

44. On 25 February, prisoners were locked into their cells at 6.00pm. Operational Support Grade (OSG) A came on duty for the night shift and at approximately 8.30pm carried out a roll check (a count of prisoners). He said in interview that when he reached Mr Sentance's cell, the observation panel was blocked. He said he called to Mr Sentance and told him to remove the obstruction. He said Mr Sentance said that he would do so. The OSG did not check that Mr Sentance had removed the obstruction that evening. He confirmed the wing roll count without seeing Mr Sentance.
45. CCTV footage shows that staff had no interaction with prisoners on Mr Sentance's corridor during the night until OSG A carried out the early morning roll check on the wing, reaching Mr Sentance's cell at 5.44am. The OSG found the observation panel still blocked. He called to Mr Sentance, but did not get a response. He remained at the cell for approximately a minute and a half, then continued checking the other cells. He returned to the cell at 5.47am and remained for a further minute and a half, then returned again at 5.49am for a further minute before leaving the cell.

46. Officer A then came onto the wing in his role as an Assistant Orderly Officer. OSG A said he told the officer that Mr Sentance's observation panel was blocked, that there was no response and he needed to contact the Custodial Manager (CM), the Night Orderly Officer (responsible for the running of the prison during the night). The OSG told the investigator that the officer said that he was returning to the office where the CM was, and he would pass the message on.
47. In interview, Officer A said that he went to Mr Sentance's cell and banged on it several times to try to get a response, although CCTV does not show him going to Mr Sentance's cell at all. The officer told the investigator that he did not say he would speak to the CM, but that he would report the blocked observation panel to the communications centre, which he said he did. Despite numerous requests, the prison has not provided us with the communications log to confirm the officer's account.
48. CCTV shows that OSG A returned to the cell at 6.48am and remained there for approximately two minutes. He then went to the office and telephoned the CM and said that he was unable to get a response from Mr Sentance. The CM and two officers went to the wing. CCTV shows that the CM went to Mr Sentance's door at 6.58am. He could not see into the cell, so called to Mr Sentance that if he did not remove the obstruction from the observation panel, staff would come in. When he got no response, he collected two officers from the wing office and returned to the cell. (Gartree's safety guidelines are that there should be a minimum of three officers present to open a cell door.) CCTV showed that they eventually opened the door at 7.00am and went into the cell.
49. Mr Sentance was suspended by a ligature made from a bed sheet attached to the hinges on a cupboard. The officers cut the ligature and lowered Mr Sentance to the bed. One of them used his radio to call a code blue emergency (meaning a prisoner is unconscious or having difficulty breathing). This prompted the communications centre to call an ambulance.
50. A nurse responded to the emergency call and she asked the officers to put Mr Sentance on the floor as soon as she got to the cell. She then began attempts to resuscitate Mr Sentance. There were, however, no signs of life, and she was unable to apply an airway. It was clear that Mr Sentance had been dead for some time, so she stopped attempts to revive him. Ambulance paramedics arrived and, at 7.20am, confirmed that he had died.

Contact with Mr Sentance's family

51. An officer was appointed as the prison's family liaison officer. She identified Mr Sentance's mother as his next of kin and travelled to her address to inform her of her son's death. In line with Prison Service guidance, Gartree offered a contribution to the cost of the funeral.

Support for prisoners and staff

52. The prison officers involved in the emergency response said in interview that managers had contacted them and offered support. There was, however, no hot debrief. This is contrary to HMPPS instructions, and the Governor will want to ensure that a debrief is held in the event of any future deaths at Gartree.

53. The prison posted notices informing other prisoners of Mr Sentance'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 Sentance's death.

Post-mortem report

54. Post-mortem reports showed that Mr Sentance died as a result of hanging. The pathologist commented that it was likely that he had been dead for some time before he was found. There were no injuries to suggest any assault prior to death.
55. Toxicology tests showed the presence of synthetic cannabinoids (PS) in Mr Sentance's system at the time of his death.

Intelligence after Mr Sentance's death

56. Intelligence reports after Mr Sentance died indicated that he had been in debt as a result of buying drugs and was possibly being bullied because of this.
57. After his death, a member of Mr Sentance's family said that they had paid money to someone for drugs on Mr Sentance's behalf. Gartree display posters in the visitors' centre and at the entrance to the prison advising families who to contact with any concerns. The Prison Advice and Care Trust (a national charity that provides support to prisoners and their families) also offer a confidential contact line through which families can pass information to the prison. There is no record that Mr Sentance's family contacted the prison before he died.

Findings

Blocked observation panels

58. The policy on managing prisons at night is contained in Prison Service Instruction (PSI) 24/2011 *Nights Function – Management and Security of Nights*. The PSI says that where observation panels are covered, the Night Orderly Officer should be informed immediately, and staff deployed to the cell. The PSI says that night operating procedures must be set out in the establishment's local security strategy. Gartree's local security policy says that any blocked observation panels must be cleared immediately.
59. When OSG A found Mr Sentance's observation panel blocked at about 8.30pm, he told him to remove the obstruction. He did not make a note in the wing observation book, he did not inform the night orderly officer, and he did not return to Mr Sentance's cell to check that the blockage had been removed.
60. During the roll check at 5.44am, Mr Sentance's observation panel was still blocked. OSG A said in interview that he told Officer A, who said that he would report it to the CM. The officer said in interview that when the OSG told him the panel was blocked, he went to Mr Sentance's cell and tried to get a response, though CCTV footage does not show him going to Mr Sentance's cell. He said he told the OSG that he would report the issue to the control room. He said that he thought that the OSG also reported it to the control room. At the time of issuing the initial report, the investigator had still not received the communications log to verify either account despite requesting this.
61. Gartree's local policy on night roll checks says that "night patrols must assure themselves that prisoners are in the correct cell by obtaining a clear view of their face". OSG A twice reported the roll check as correct, even though he had not seen Mr Sentance.
62. Although there is disparity between the OSG's and the officer's accounts of what happened, it is clear that Mr Sentance's observation panel was blocked for over nine hours and that he did not respond to verbal prompts. Despite this, nobody made any attempt to see him, and the Night Orderly Officer was not informed. Nobody tried to see if Mr Sentance was well until after OSG A was still unable to get a response from him at 6.48am, over 10 hours since he first found the observation panel blocked. We make the following recommendations:

The Governor should commission an investigation into the failure to follow policy when Mr Sentance blocked his cell observation panel, with a view to considering whether disciplinary action is warranted for OSG A or Officer A.

The Governor should ensure there are robust management checks to ensure that roll checks are carried out in line with guidance.

The Governor should remind night staff of the correct procedures when an observation panel is blocked.

Key Worker Scheme

63. The purpose of the key worker scheme is to give each prisoner a point of contact who will meet them regularly to help and support them. All prison officers who work on a residential unit will be allocated a maximum of six prisoners. They are expected to spend an average of 45 minutes per prisoner per week on the key worker role, which includes individual time and meaningful conversations with each prisoner. Governors must ensure that time is made available for this.
64. Mr Sentance had a named key worker, but his electronic prison record (known as NOMIS) contained no key work entries during his 11 months at Gartree, either by his named key worker or any other individual key work sessions. There were no entries at all between the report of him being engaged in a fight in September 2019 and being found in possession of hooch in November 2019. There are no entries at the anniversary of his sisters' deaths, a time that had been noted as a potential trigger for him to use drugs.
65. While the Offender Management In Custody model had not been fully signed off at the time of Mr Sentance's death, we are very concerned that there is little evidence that staff had any meaningful interaction with Mr Sentance. Intelligence received after Mr Sentance's death suggested that he may have been in debt and being bullied. This was a missed opportunity to assess his risk of suicide and self-harm, or to allow him to discuss anything that was causing him concern in a safe or trusted relationship. We, therefore, recommend:

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

Allegations of bullying

66. On 12 February, Mr Sentance told staff that he had overheard prisoners indicating that he would be assaulted and thought this was due to his index offences. Staff completed a Challenge, Support and Intervention (CSIP) referral and investigation form. The form contains no further information, and on 18 February it is noted that as there had been no further incidents there was no need for intervention. The prison told the investigator that this decision would have been taken after discussions with Mr Sentance and with any others identified. There were no notes of any such discussions, and no such references on Mr Sentance's record.
67. It is not clear from records what support was given to Mr Sentance when he felt under threat. Intelligence received after he died indicated that he may have incurred drug debts, was possibly being bullied, and had been assaulted. Staff were apparently not aware of this, but there is no evidence of staff engagement with Mr Sentance to gauge whether he was facing such problems or needed further support. We make the following recommendation:

The Governor should satisfy himself that procedures to address allegations of bullying are sufficiently robust, and that appropriate support is offered to victims.

Substance misuse

68. Mr Sentance had a history of substance misuse. He engaged with substance misuse services in prison, but as recently as January 2020, was found under the influence of drugs, and failed a drug test. He was referred to the substance misuse team, but he subsequently declined to engage with them. He then failed another test on 11 February.
69. Gartree's drug strategy says that prisoners who fail drug tests more than once should be assessed for frequent testing. This would be across a three-month period, the first test being not within 28 days of the last failed test. Mr Sentance died before this period had expired, so the prison had not started the frequent testing process.
70. Intelligence after his death suggested that Mr Sentance had been using drugs and had incurred debts because of it. His family said that they had paid debts on his behalf (although there is no evidence that they told the prison).
71. It is possible that drug misuse contributed to Mr Sentance's decision to take his life by affecting his mental state either directly or indirectly (as a result of his debts or bullying). We are concerned that staff were not fully aware of Mr Sentance's drug use, despite its apparent extent and the possible impact it had on his vulnerability.
72. Drugs are a problem in much of the prison estate. Gartree has a strategy to address both the supply of, and demand for, PS and other illicit drugs. It includes numerous actions intended to reduce the supply of drugs into the prison and the movement of drugs around the prison. Nonetheless, both HM Inspectorate of Prisons and the Independent Monitoring Board have expressed concern about the ready availability of drugs at Gartree, and the IMB specifically raised the issue of problems increasingly arising from drug debts. It seems clear that Mr Sentance was buying drugs, which led to debts and bullying, yet staff were unaware of the extent of his involvement. We make the following recommendation:

The Governor should ensure that the key drug issues are identified, that the local drugs strategy addresses these key issues, and that staff remain vigilant to signs that a prisoner is involved in drug use or supply.

PPO Liaison

73. Prison Service Instruction (PSI) 58/2010 makes it mandatory for prisons to provide evidence to the Ombudsman's office for the purpose of our investigations. At various points during the investigation, the investigator had difficulty in getting responses from liaison officers at Gartree. He had difficulty in getting access to witnesses for interview. He also made requests for evidence that were not responded to. We are concerned that our investigation was significantly delayed by the lack of engagement from Gartree. Although we raised our concerns with the Governor, we did not receive a response. We make the following recommendation:

The Governor should ensure that all evidence relevant to a death in custody is retained and that evidence is made available to the PPO, in line with PSI 58/2010.

Mr Sentance's healthcare

74. The clinical reviewer noted that Mr Sentance had no physical health problems while he was at Gartree. There was no evidence to suggest any symptoms of depression. He received appropriate support from substance misuse services, and that remained available even though he declined to engage with them. The reviewer concluded that the care received was at least equivalent to that which would have been available in the wider community.

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