Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Neil Conway a prisoner at HMP Hull on 20 December 2018

A report by the Prisons and Probation Ombudsman

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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 Neil Conway died in hospital on 20 December 2018 after being found hanging in his cell at HMP Hull two days before. He was 37 years old. I offer my condolences to Mr Conway's family and friends.

The day before he was found hanging in his cell, Mr Conway had been sentenced to 18 months in prison for offences against his partner. He had also been given a five-year restraining order.

My investigation found no evidence that Mr Conway's risk of suicide and self-harm was assessed as it should have been when he returned from court. He was also not seen by healthcare staff as he should have been. An opportunity to support him, and reduce his risk of suicide, could have been missed.

I am concerned that Mr Conway was not offered support with his alcohol misuse. He told a nurse about his issues with alcohol when he first arrived at Hull, and he told his keyworker. Neither made a referral to the substance misuse team.

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 **August 2019**

Contents

Summary 1

The Investigation Process 3

Background Information 4

Key Events 6

Findings 9

Summary

Events

1. Mr Neil Conway was remanded in prison custody on 19 November 2018, charged with violent offences against his partner, and sent to HMP Hull. The reception nurse noted that Mr Conway said he had issues with alcohol and regularly drank alcohol in excess of the recommended amount.

2. On 28 November, Mr Conway met the prison officer who was his keyworker. He said his offending was linked to binge drinking and he knew he had to address this, and he was worried that he could not contact his partner (a non-contact order was in place).

3. Mr Conway saw his keyworker again on 3 and 12 December. On both occasions he expressed feelings of anxiety about his court case and having no contact with his partner, his child, or anyone outside the prison.

4. On 17 December, Mr Conway attended court where he was given an 18-month prison sentence and a restraining order preventing contact with his partner for five years.

5. On 18 December, at around 8.15am, Mr Conway spoke to a substance misuse practitioner and handed her a questionnaire and self-referral form. The substance misuse practitioner said she would read it and return to see him later to carry out an assessment.

6. At around 9.45am, an officer went to unlock Mr Conway for association and found him hanging in his cell. The officer used his radio to call for assistance. Other members of staff arrived and cut Mr Conway down, before starting cardiopulmonary resuscitation (CPR). Healthcare staff arrived shortly afterwards and took over CPR.

7. Paramedics arrived at 10.02am and managed to resuscitate Mr Conway before taking him to hospital. Mr Conway did not regain consciousness and died two days later, on 20 December.

Findings

8. There is no evidence that staff assessed Mr Conway's risk of suicide and self-harm when he returned from court on 17 December. He should also have been assessed by healthcare staff following his change in status from remand to sentenced prisoner, but this did not happen.

9. The reception nurse did not fully explore Mr Conway's alcohol misuse with him. We found no evidence that the nurse used the appropriate substance misuse audit tool, recorded the results of the audit, or offered Mr Conway support with his alcohol misuse.

10. Mr Conway's keyworker met with him regularly. However, we consider that the keyworker scheme was ineffective in offering meaningful support to Mr Conway.

11. The officer who found Mr Conway hanging in his cell did not call a medical emergency code. Other officers began CPR almost immediately and the medical emergency code was called very shortly afterwards. While we do not consider that the failure to call the correct code affected the eventual outcome for Mr Conway, it could be crucial in future incidents.

Recommendations

- The Governor should ensure that prisoners passing through reception on return to the prison after a court appearance are:
    - screened to assess their risk of suicide and self-harm; and
    - assessed by healthcare staff when there has been a change in their custodial status.
- The Head of Healthcare should ensure that reception staff:
    - complete the required substance misuse audits;
    - explore any substance misuse issues with the prisoner, offering support and making onward referrals, as appropriate; and
    - clearly record the results of the audit and outcomes in the prisoner's medical record.
- The Governor should ensure that:
    - the keyworker scheme provides meaningful support to prisoners, particularly in relation to the identification, discussion and recording of significant events; and
    - where significant issues are identified, keyworkers take appropriate follow up action or make onward referrals to offer support to the prisoner.
- The Governor and Head of Healthcare should ensure that all staff are aware of the correct medical emergency codes and have appropriate training in the use of emergency call signs.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Hull informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

13. The investigator obtained copies of relevant extracts from Mr Conway's prison and medical records.

14. NHS England commissioned a clinical reviewer to review Mr Conway's clinical care at the prison.

15. The investigator and clinical reviewer jointly interviewed nine members of staff at Hull. The investigator interviewed one member of staff separately. The interviews took place between April and June 2019.

16. We informed HM Coroner for East Riding and Kingston Upon Hull of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

17. One of the PPO's family liaison officers contacted Mr Conway's father to explain the investigation and to ask if the family had any matters they wanted the investigation to consider. Mr Conway's father wanted to know if his son was being monitored as he was vulnerable and had recently been sentenced.

18. We shared our initial report with HM Prison and Probation Service (HMPPS). HMPPS raised one factual inaccuracy which has been corrected in this report. They also provided an action plan, which is annexed to this report.

19. We provided a copy of our initial report to Mr Conway's father. He made no comments.

Background Information

HMP Hull

20. HMP Hull is a local prison that holds up to 1,056 men in ten wings. City Healthcare Partnership provides health services at the prison. The prison has a wellbeing unit to support prisoners with complex needs, which are difficult to meet in the normal prison environment. The unit includes a specialist palliative care cell. GP surgeries are held four days a week, with an out of hours service at other times.

21. In August 2018, Hull 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 focusing on reducing violence, improving living conditions, preventing drugs from entering the establishment and enhancing the leadership and training available to staff.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Hull was in April 2018. Since their last inspection in 2014, inspectors found an increase in prisoners taking their own lives and incidents of self-harm. Although they acknowledged that the prison was working hard to tackle this, inspectors were concerned about the quality of casework for those in crisis and felt there was a greater need to offer support to vulnerable prisoners. Despite an increase in violence, inspectors noted that most prisoners felt safe, respected and knew of someone they could turn to for help. Inspectors found strong leadership and a positive staff culture which helped to maintain reasonably good outcomes for prisoners during challenging times.

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 ending 28 February 2018, the IMB noted that prisoners were treated fairly and humanely and every effort was made to prepare them for release. The Board noted that officers were preparing for a ‘keyworker’ scheme to improve their knowledge of individual prisoners and how to interact with them.

Previous deaths at HMP Hull

24. Mr Conway’s death was the 10th at Hull since December 2016. Of the previous deaths, seven were from natural causes, one was drug-related, and one was self-inflicted. There has been one death since, from natural causes. We have previously made a recommendation about the correct use of emergency codes.

The keyworker system

25. Offender Management in Custody (OMiC) is a key part of the Prison Service’s response to self-inflicted deaths, self-harm and violence in prison. It is intended to improve safety by engaging with prisoners, building better relationships between staff and prisoners and helping prisoners settle into life in prison. It

includes the keyworker system which is currently being rolled out across the prison estate.

26. All prisoners in the male closed estate must be allocated a keyworker (a prison officer) who is responsible for engaging, motivating and supporting them through the custodial period. Each keyworker is responsible for five to six prisoners and Governors must ensure that time is made available to allow keyworkers to spend an average of 45 minutes per prisoner per week on the keyworker role, including individual time with each prisoner. Within this allocated time, keyworkers can vary individual sessions in order to provide a responsive service, reflecting individual need and stage in the sentence. A keyworker 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

27. Mr Neil Conway was remanded in prison custody on 19 November 2018 and sent to HMP Hull. He had been charged with domestic violence offences against his partner and there was a non-contact order in place. The Person Escort Record (PER – a document that accompanies prisoners between police, court and prisons and sets out the risks they pose) said that Mr Conway had taken an overdose 4-5 years ago and he suffered from hallucinations. The PER did not mention any current concerns about suicide or self-harm.

28. Mr Conway had a reception healthcare screening with a nurse. He told the nurse that he suffered from anxiety and had been detained under the Mental Health Act approximately four years ago, but he said he had no current thoughts of suicide or self-harm. Mr Conway also said that he had had recent problems with alcohol misuse and the nurse recorded that he said he was drinking 24 units of alcohol a week before coming into prison.

29. The nurse noted that he had no concerns about Mr Conway. He did not refer him to the substance misuse or mental health teams. The nurse told the investigator and the clinical reviewer that he did not think 24 units of alcohol was particularly excessive and would not necessarily trigger a referral to the substance misuse team. He also said that he "would have" completed an alcohol audit and he "would have" asked Mr Conway if he needed support with his alcohol misuse, but this was not recorded on Mr Conway's medical record.

30. On 20 November, Mr Conway had a second healthcare screening with another nurse where they discussed his asthma care plan. The nurse did not record anything in Mr Conway's medical notes about substance misuse issues.

31. Mr Conway later met with an offender supervisor to complete a basic custody screening. Mr Conway said that he had no mental health or substance misuse issues. The offender supervisor told the investigator and the clinical reviewer that the basic custody screening is based on what the prisoner says and the information available to her at the time was limited.

32. On 28 November, Mr Conway met his keyworker, a prison officer, for the first time. Mr Conway's keyworker noted in Mr Conway's prison record (NOMIS) that Mr Conway spoke about his offence against his partner. Mr Conway said that most of his offending was caused by alcohol binges and he wanted help to address this. His keyworker also noted that Mr Conway was concerned that he could not contact his partner and that he also had no contact with his parents or anyone else outside the prison.

33. Mr Conway's keyworker met with Mr Conway again on 3 December. He noted that Mr Conway said he was feeling more settled on D Wing and that he was associating with other prisoners. He also said he wanted to engage with education or employment. Mr Conway mentioned again that he was not having contact with anyone outside the prison and that he was concerned about the sentence he would receive.

34. On 12 December, Mr Conway's keyworker met with Mr Conway again. Mr Conway had started a maths course by this time and said he was not happy with

it but would continue. Mr Conway told his keyworker that he struggled with anxiety and was anxious about his court case and the sentence he might get. Mr Conway's keyworker recorded that he told him to keep himself busy and told him he would see him after court to help him with sentence progression.

35. Mr Conway's keyworker told the investigator that the main role of the keyworker is to encourage prisoners' progression through their sentence and promote good staff/prisoner relationships. He said that, although he was aware of Mr Conway's alcohol misuse and mental health issues, he did not see it as his role to make referrals. He felt his role was to encourage Mr Conway to seek the help he needed. He also said that he thought the healthcare team would make referrals if they had any concerns from the notes he had put onto NOMIS. He said he felt Mr Conway was struggling with issues that many other prisoners face so he had no specific concerns about his risk of suicide or self-harm. He said he was not on duty on the day that Mr Conway went to court but he would have expected any necessary support to have been provided to Mr Conway as part of the reception process when he returned from court.

36. On 17 December, Mr Conway was assessed by a nurse as suitable to attend court. The nurse noted no concerns in relation to suicide or self-harm. Mr Conway attended court where he was given an 18-month prison sentence and a restraining order preventing contact with his partner for five years.

37. The Supervising Officer (SO) who was working in reception when Mr Conway returned to the prison at 4.21pm, told the investigator that his role was minimal. He would have checked basic details, such as the name, but he would not have asked Mr Conway about his change of circumstances or assessed his risk. The SO said these further checks should have been done by one of the reception officers and Mr Conway should also have been seen by healthcare because of his change in circumstances. However, nothing is recorded in Mr Conway's NOMIS or medical record to say that he was assessed by a reception officer or healthcare staff on his return to the prison.

Events of 18 December

38. On 18 December at around 8.15am, Mr Conway approached a substance misuse practitioner, while she was on the D Wing corridor. She told the investigator and the clinical reviewer that Mr Conway handed her a questionnaire and a self-referral form. She said she asked Mr Conway if he was already known to the substance misuse service and he said no. She said she took the paperwork from Mr Conway and said she would read it and return to see him later to carry out an assessment. She said that Mr Conway seemed fine with her response and she had no concerns about him at that time.

39. At approximately 8.20am, Officer A locked up all prisoners, which was the standard process before unlocking those who were due out for education, employment or activity. At approximately 8.35am, Officer A unlocked Mr Conway's cell so that his cellmate could go to the gym, and then relocked the cell, leaving Mr Conway alone.

40. At around 9.45am, Officer A went to unlock Mr Conway for association and found him hanging in his cell. He had used a strip of bedding as a ligature and tied it to the top bunk bed. Officer A shouted for urgent staff assistance.

41. Officer B was the first to respond to Officer A's shouts for assistance and they both went into the cell where Officer A cut Mr Conway down and placed him on the floor. Officer C arrived and he and Officer B started cardiopulmonary resuscitation (CPR). A SO arrived and used his radio to call a code blue (a medical emergency code used when a prisoner is unconscious or having difficulty breathing, which alerts the control room to call an ambulance immediately). A prison manager arrived at approximately 9.51am and took over CPR from Officers B and C.

42. Two nurses arrived at approximately 9.53am with emergency medical equipment and took over CPR. The nurses were unable to get a response from Mr Conway.

43. Paramedics arrived at 10.02am and managed to resuscitate Mr Conway before taking him to hospital. Mr Conway did not regain consciousness and died two days later, on 20 December.

Contact with Mr Conway's family

44. Mr Conway had not provided the prison with next of kin details but staff were able to trace his father from previous records. A family engagement supervising officer contacted Mr Conway's father by telephone at approximately 12.30pm on 18 December to let him know that his son was in hospital. Mr Conway's father and other family members went to the hospital and were with him when he died.

45. The prison contributed to the cost of Mr Conway's funeral, in line with Prison Service instructions.

Support for prisoners and staff

46. The duty governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. After Mr Conway died, the duty governor debriefed staff who were present with him at the hospital. The prison's care team also offered support.

47. The Governor posted a notice for prisoners informing them of Mr Conway's death and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Conway's death.

Post-mortem report

48. The post-mortem report concluded that Mr Conway's death was due to hanging. Toxicology results showed no traces of alcohol or illicit substances.

Findings

Identifying and managing Mr Conway's risk of suicide and self-harm

49. Prison Service Instruction (PSI) 64/2011: *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)* sets out the risk factors and triggers that might increase a prisoner's risk of suicide and self-harm. They include relationship problems and charges of violence against a partner, both of which applied to Mr Conway. They also include receiving a longer sentence than expected.

50. PSI 07/2015: *Early Days in Custody*, sets out guidance and mandatory actions for prison staff on reception procedures. This includes that all prisoners passing through reception must be risk assessed for potential harm to themselves, to others and from others. It makes it clear that this process is the same regardless of whether the prisoner is entering the prison for the first time or is returning after a temporary absence, such as after attending court. The PSI says that the Person Escort Record (PER) and any other available information, including suicide and self-harm (SASH) warning forms, must be examined by reception staff and the prisoner must be interviewed to assess their risk of suicide and self-harm.

51. Mr Conway attended court on 17 December and was sentenced to 18 months in prison. He was also given a five-year restraining order preventing contact with his partner. When he returned to Hull and passed through reception, he should have been assessed for his risk of suicide and self-harm. We have seen no evidence that this happened.

52. When Mr Conway was sentenced at court, this constituted a change in custodial status, from a remand prisoner to a sentenced prisoner. Prison Service Order (PSO) 3050: *Continuity of Healthcare* says that all prisoners should be assessed by healthcare staff following a change in custodial status. However, we have seen no evidence that Mr Conway was assessed by healthcare staff at Hull when he returned from court.

53. We consider that Mr Conway had risk factors for suicide and self-harm, which were not assessed on his return from court. We therefore make the following recommendation:

The Governor should ensure that prisoners passing through reception on return to the prison after a court appearance are:

- **screened to assess their risk of suicide and self-harm; and**
- **assessed by healthcare staff when there has been a change in their custodial status.**

Substance misuse

54. Mr Conway had a history of alcohol dependency and there was evidence of this in his medical record. We acknowledge that this information may not have been immediately available to the nurse at the time of the reception healthcare

screening, but the nurse was able to establish that Mr Conway had problems with alcohol and he reported drinking more than the recommended weekly limit. However, we found no evidence that the nurse used the appropriate alcohol audit tool or discussed Mr Conway's alcohol consumption with him. We would also have expected to see a referral made to the substance misuse service. We make the following recommendation:

The Head of Healthcare should ensure that reception staff:

- **complete the required substance misuse audits;**
- **explore any substance misuse issues with the prisoner, offering support and making onward referrals, as appropriate; and**
- **clearly record the results of the audit and outcomes in the prisoner's medical record.**

Keyworker support

55. Mr Conway's keyworker met with him on a weekly basis and made detailed notes of their conversations. However, despite Mr Conway telling his keyworker about his alcohol misuse, relationship issues, feelings of isolation from his family and fears about his sentence, we found no evidence that he referred him on to appropriate services to offer support or reduce the likelihood of self-harm. Mr Conway's keyworker did not consider it was his role to make referrals and said he expected this would be picked up by healthcare staff from the notes he made in NOMIS.

56. While we recognise that the keyworker scheme was new to Hull at the time, we are concerned that it was not effective in providing Mr Conway with the support he needed and it was left to him to be proactive in seeking appropriate help. We are particularly concerned about the lack of support for Mr Conway's alcohol misuse and when he returned to prison after being sentenced at court. We therefore make the following recommendation:

The Governor should ensure that:

- **the keyworker scheme provides meaningful support to prisoners, particularly in relation to the identification, discussion and recording of significant events; and**
- **where significant issues are identified, keyworkers take appropriate follow up action or make onward referrals to offer support to the prisoner.**

Emergency response

57. PSI 03/2013: *Medical Emergency Response Codes* says that all staff must be made aware of and understand their responsibilities during medical emergencies. The PSI requires staff to radio a medical emergency code to communicate the nature of a medical emergency efficiently. The code triggers healthcare staff to take the relevant equipment to the scene, and control room staff to call an ambulance without delay.

58. When Officer A found Mr Conway hanging in his cell, he should have used a medical emergency code blue, which indicates that a prisoner is unconscious or having breathing difficulties. He did not do so and instead shouted for urgent assistance.

59. Although Officer A did not call a code blue, we found that other officers arrived almost immediately and began CPR and that the SO used his radio to call the correct emergency code one or two minutes afterwards. The clinical reviewer considered that it was unlikely that this short delay in summoning nurses and calling an ambulance affected the eventual outcome for Mr Conway. Nevertheless, we are concerned that failure to use the correct emergency code could make a significant difference in future incidents. We therefore make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff are aware of the correct medical emergency codes and have appropriate training in the use of emergency call signs.

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