

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Leam Chambers, a prisoner at HMP Humber, on 6 October 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.

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 Leam Chambers died from synthetic cannabinoid toxicity on 6 October 2018, while a prisoner at HMP Humber. He was 27 years old. I offer my condolences to his family and friends.

Mr Chambers had a history of mental health issues and was managed frequently under suicide and self-harm prevention procedures, known as ACCT. He had a history of using illicit substances, including psychoactive substances (PS) while in custody.

Although Mr Chambers was being managed under ACCT procedures when he died, we have seen no evidence that his death was self-inflicted (or that it was anything other than accidental).

I am satisfied that Mr Chambers received appropriate support under ACCT procedures during his time in prison. However, I am concerned that he was able to access, conceal and use illicit substances without staff knowing. My investigation also found that some welfare checks on Mr Chambers were either not completed or inadequately completed on the evening of 5 October and the morning of 6 October.

I am concerned about the number of deaths my office investigates in which PS has played a part and about the availability of PS across the prison estate. Although Humber has a sound local drugs strategy, some of the staff we interviewed were not aware of it and had not had drug awareness training. While I recognise the difficulty in preventing prisoners from accessing drugs, staff missed opportunities to identify Mr Chambers' substance misuse.

We have previously expressed concerns that individual prisons were being left to develop local strategies to reduce the supply and demand for drugs. I am pleased that HM Prison and Probation Service issued a Prison Drugs Strategy earlier this year to provide guidance to prison governors on how to tackle the issue. Humber will need to implement the initiatives in the strategy to try to prevent deaths like that of Mr Chambers. The prison is part of the 10 Prisons Project and I hope that the extra funding from that will help Humber address the drugs problem robustly.

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 2020**

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# Summary

## Events

1. In December 2015, Mr Leam Chambers was remanded to HMP Nottingham, charged with burglary. He was sentenced to six years in prison. Mr Chambers had been diagnosed with mental health issues and had a significant history of self-harm and substance misuse.
2. On 11 September 2018, he was transferred to HMP Humber subject to ongoing suicide and self-harm prevention procedures, known as ACCT.
3. Mr Chambers settled well at Humber and mixed well with other prisoners. He had frequent contact with family and friends. Although Mr Chambers had a history of substance misuse in prison, staff at Humber never recorded that he was under the influence of illicit substances while he was there. However, staff noted his speech was slurred at an ACCT review on 19 September.
4. During his time at Humber, Mr Chambers continued to be monitored under ACCT procedures and had access to mental health services. He harmed himself on 25 September.
5. On 5 October, Mr Chambers routinely mixed with prisoners on the wing and staff had no concerns about him. He was checked four times under ACCT procedures during the night, the last time at 5.37am, when an officer said he saw him move in bed. At 8.41am, an officer unlocked Mr Chambers and found that he had died. He had been dead for some time when he was found.
6. The post-mortem found that Mr Chambers died from the effects of a synthetic cannabinoid (a form of PS). Intelligence submitted after Mr Chambers' death suggested that staff had previously seen him under the possible influence of drugs and that prisoners had told staff that illicit substances were available on the wing. Tablets and drug paraphernalia were found in Mr Chambers' cell after his death.

## Findings

7. Although Mr Chambers was being managed under ACCT procedures when he died, there is nothing to suggest that his death was self-inflicted or that it was anything other than accidental.
8. Despite evidence that staff had seen Mr Chambers under the influence of drugs during his time at Humber, they did not report these incidents as they should have done.
9. We are concerned at the continued availability of illicit substances at Humber. Despite a sound local drugs strategy, more needs to be done to limit their supply and demand. The publication of the National Drug Strategy should help Humber to develop its own local strategy further.
10. During the night before Mr Chambers was found dead in his cell, officers failed to carry out adequate ACCT checks. On one occasion, an officer failed to check on

Mr Chambers but recorded that he had, while other night staff made only cursory checks. Mr Chambers was also not checked by the early start officer as he should have been. We cannot say if the outcome would have been different for Mr Chambers if more thorough checks had been carried out, but it might have been.

11. The clinical reviewer concluded that the healthcare that Mr Chambers received at Humber was equivalent to that which he could have expected to receive in the community.

## **Recommendations**

- The Governor should ensure that the key drug issues at Humber are identified and that the prison's local drugs strategy is kept under review to ensure they are addressed.
- The Governor should ensure that all staff complete an intelligence report when a prisoner is suspected of being under the influence of an illicit substance or involved in the prison's drug culture.
- The Governor should ensure that all staff are aware of the local substance misuse and supply reduction strategy and receive drug awareness training.
- The Governor should ensure that:
  - staff completing roll checks, welfare checks, or ACCT checks satisfy themselves that there are no immediate causes for concern; and
  - officers record their own checks on the appropriate documents.

## The Investigation Process

12. 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. No one responded.
13. He obtained copies of relevant extracts from Mr Chambers' prison and medical records.
14. NHS England commissioned an independent clinical reviewer to review Mr Chambers' clinical care at the prison.
15. The investigator interviewed eleven members of staff and one prisoner, some jointly with the clinical reviewer.
16. We informed HM Coroner for East Riding and Kingston Upon Hull of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
17. We contacted Mr Chambers' next of kin to explain the investigation and ask if she had any matters that she wanted us to consider. She asked if Mr Chambers' medical care was adequate and in particular, she wanted to know about the mental healthcare he received. She was concerned that he was not found until 8.45am and asked how often he was checked. Mr Chambers' next of kin asked about his self-harming while in prison and whether he was being managed under ACCT procedures at the time of his death and appropriately located in a single cell. Mr Chamber's family received a copy of the initial report and we have addressed concerns raised by Mr Chambers' family in our report and through separate correspondence.

## **Background Information**

### **HMP Humber**

18. HMP Humber is a medium security prison in Yorkshire that holds approximately 1,000 men. It was created in 2014 by the merger of two previously separate prisons, HMP Wolds and HMP Everthorpe. City Health Partnership provides healthcare services. There are always healthcare staff on duty.
19. In August 2018, 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 focused on reducing violence, improving living conditions, preventing drugs from entering the prison and enhancing the leadership and training available to staff.

### **HM Inspectorate of Prisons**

20. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Humber in December 2017. Inspectors reported that that two thirds of prisoners said that it was easy to get drugs at Humber and a third of prisoners said that they had developed a drug problem while there. Inspectors reported that the use of psychoactive substances (PS) was particularly bad, although the levels of supply had reduced after additional security measures were introduced, including the photocopying of mail to prevent paper soaked in PS from entering the prison. Inspectors reported that intelligence did not always result in timely suspicion drug testing and searching taking place, with prisoners suspected of using drugs often not being 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 their latest annual report for the year to December 2017, they reported that PS continued to be a major problem in the prison and noted that the substance was responsible for exacerbating the vulnerabilities of prisoners.

### **Previous deaths at HMP Humber**

22. Mr Chambers’ death was the second drug-related death at Humber since September 2016. In the same period, there were also two self-inflicted deaths, two deaths from natural causes and one accidental death. Since Mr Chambers’ death, there have been a further four deaths, of which two were self-inflicted and two were from natural causes.
23. In our report into the death of a prisoner who died from an overdose of drugs in February 2018, we raised concerns about the availability of drugs at Humber. Our investigation into Mr Chambers’ death has raised similar concerns.

## **Assessment, Care in Custody and Teamwork (ACCT)**

24. 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.
25. 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. Prison Service Instruction (PSI) 64/2011 on safer custody sets out how staff should operate ACCT procedures.

## **Psychoactive substances (PS)**

26. Psychoactive substances are a serious problem across the prison estate. They are difficult to detect and can affect people in many 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.
27. 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.
28. 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.

# Key Events

## Background

29. In November 2015, Mr Leam Chambers was remanded to HMP Nottingham, charged with burglary. In December, he was found guilty and sentenced to six years in prison. Mr Chambers had served previous custodial sentences, including at HMP Humber.
30. Mr Chambers had a significant history of self-harm. He frequently cut himself, swallowed items (which often resulted in hospital treatment) and made ligatures. From the time he was remanded into custody until his death, Mr Chambers was monitored under suicide and self-harm procedures thirteen times. He was treated for an acute psychotic paranoid illness in September 2018 and was also assessed as displaying symptoms consistent with attention deficit hyperactivity disorder (ADHD).
31. Mr Chambers also had a history of substance misuse. During his time in custody, he continued his use of illicit substances, telling staff that he used PS. He tested positive for PS in September 2017. Mr Chambers sourced his drugs from other prisoners and intelligence suggested that he had been planning to receive drugs during prison visits. In February 2018, a letter addressed to Mr Chambers tested positive for PS and in July 2018, he received a letter suggesting that PS could be sent to him in HMP Moorland if the prison did not test prisoner mail for the drug. In March 2018, Mr Chambers was reported to be under the influence of drugs on several occasions.
32. On 10 May 2018, Mr Chambers was transferred to HMP Moorland. In early August, he was moved to the prison's segregation unit after he was found climbing the wing's railings. His behaviour deteriorated and he was monitored under ACCT procedures after making threats to end his life. His behaviour was described by staff as angry, irate and volatile.
33. On 21 August, Mr Chambers' behaviour started to improve. He told staff that he was looking forward to his release and was willing to work with staff. Although his level of security was reduced, it was increased again on 26 August, after he threw hot water at an officer. Mr Chambers said that his acts of violence were due to his mental health problems.
34. On 1 September, staff noted that Mr Chambers' behaviour had improved, he interacted well and looked relaxed. At an ACCT review on 4 September, he expressed paranoid thoughts, but denied thoughts of self-harm. He asked for a transfer, which was approved, and on 7 September, he told staff that he was in a better frame of mind, knowing that he would move to Humber.
35. On 11 September, Mr Chambers was transferred to Humber. At an ACCT review held at Moorland before his transfer, he denied having thoughts of self-harm and said that he was looking forward to his move. During the review, a psychiatrist noted that Mr Chambers should be reviewed soon after his transfer to Humber.

36. When Mr Chambers arrived at Humber, a nurse assessed him at an initial transfer reception screening. The nurse identified that Mr Chambers' immediate healthcare needs related to his mental health. He referred him urgently to the mental health team. (When the mental health team considered the referral, they concluded that he should be seen for an initial assessment within two weeks.)
37. Although Mr Chambers told nurse that he had not used illicit drugs in the previous month, the nurse nonetheless referred him to the substance misuse team.
38. A Supervising Officer (SO) chaired a further ACCT review with the nurse. Mr Chambers said that he was happy to be back at Humber but still had some bouts of paranoia. Mr Chambers asked for a single cell but was told that he would have to share.
39. On 12 September, a member of staff from the substance misuse team spoke to Mr Chambers. Mr Chambers told him that he had stopped using PS as well as other drugs and therefore did not need to engage with the substance misuse team. He explained to Mr Chambers how he could reduce his risk of harm from substance misuse in prison.
40. That day, an officer introduced himself to Mr Chambers as his offender supervisor. Mr Chambers told him that he had no thoughts of self-harm and that he wanted to live with his next of kin on release. The officer talked to him about engaging with the substance misuse team. Mr Chambers said that they had seen him but that he did not want to see them again as he had not taken drugs for several months.
41. On 14 September, Mr Chambers asked an officer if it would be possible for him to transfer to HMP Doncaster or HMP Ranby to be nearer his mother who had difficulty visiting him at Humber due to illness. His request was submitted.
42. On 15 September, Mr Chambers moved cells.
43. On 19 September, a SO and a nurse held an ACCT review. Mr Chambers asked about his request for a transfer and asked to see the mental health team. The SO noted that Mr Chambers was making plans for the future and hoped to move wings to be near staff and other prisoners he knew. Although Mr Chambers denied having thoughts of self-harm, the SO and the nurse decided that ACCT monitoring should continue until the mental health team had seen him.
44. The nurse later noted in Mr Chambers' medical record that his speech had been slurred during the ACCT review. She noted that he had said that this was because he had just woken up. She said that she asked the SO about Mr Chamber's speech as she thought that Mr Chambers might have been under the influence of drugs. She said that the SO assured her that this was how Mr Chambers normally spoke. The SO told us that he could not recall if Mr Chambers speech was slurred but said that it appeared normal. He said that just before the review, he and the nurse had woken Mr Chambers up.
45. During his time at Humber, Mr Chambers spoke frequently with family and friends by telephone. Conversations were often about arranging visits and during the calls, Mr Chambers would talk of his release, saying that he was finished with prison and

would not be coming back. In some calls, Mr Chambers asked for money to be paid into his prison account and for pictures to be sent in.

46. On 25 September, Mr Chambers told staff that he had swallowed parts of his television. He was sent to the hospital for treatment and later returned to the prison.
47. At an ACCT review on 28 September, Mr Chambers told a SO and a nurse that he wanted to transfer to Doncaster. Mr Chambers denied thoughts of self-harm. He said that his self-harm enabled him to get what he wanted in prison. He denied that he had harmed himself in the community.
48. On 1 October, Mr Chambers received a visit from his mother and female friends. He spoke briefly to his mother by telephone the following day.
49. On 2 October, a mental health nurse completed Mr Chambers' mental health assessment, three weeks after the initial referral was made. Mr Chambers told the nurse that he felt low in mood and had difficulty concentrating. Mr Chambers was told that he would be offered one-to-one sessions which would support him to develop strategies to manage his behaviour and impulsiveness, and that he would be referred to the prison psychiatrist who would review his medication. He told her that he was not using any illicit substances in prison and although he admitted that he had previously used PS, he said that he had stopped as it made him feel unwell. He said that he felt better since he had not used PS.
50. On 3 October, Mr Chambers spoke to his next of kin again. He told her that he was feeling better and that a friend had brought him some new clothes and trainers. He asked his next of kin to send him some money. Mr Chambers told his next of kin that he would speak to her the following day.
51. That day, a consultant psychiatrist assessed Mr Chambers and reviewed whether to re-prescribe the concerta medication (used to treat ADHD) which he had asked for. He concluded that Mr Chambers did not present with symptoms of ADHD and that he appeared to be preoccupied with securing a prescription for concerta and for an increase in his dose of diazepam (a tranquiliser, sometimes called valium). He told Mr Chambers about the negative impact of concerta on the heart and the dangers of taking it while using illicit substances such as PS. He concluded that he needed more information to establish whether Mr Chambers' prescription for concerta had been stopped because of Mr Chambers' use of PS.
52. On the evening of 4 October, Mr Chambers spoke to his next of kin for the last time. He told her that he was okay, had a new tracksuit which he had bought in exchange for cigarette vapes, and had never had it so good. Mr Chambers asked his next of kin to send him some money and asked when she would book her next visit to see him. Mr Chambers said he would call her in a few days.
53. An officer, his personal officer, described Mr Chambers as sociable and popular with other prisoners on the wing. The officer said that she never saw him under the influence of drugs. An officer described Mr Chambers as talkative and always having "a laugh" with other prisoners. She said that he had never seen Mr Chambers under the influence of drugs or with slurred speech.

54. At lunch time on 5 October, during an ACCT check, Mr Chambers told an unidentified officer that he was okay. After lunch, Mr Chambers was unlocked for the afternoon association period. CCTV shows that he talked to and mixed with other prisoners on the wing. At 4.55pm, an officer locked Mr Chambers behind his cell door and noted in the ACCT document that he raised no concerns.
55. A prisoner who lived near Mr Chambers' cell, said that he had never seen Mr Chambers under the influence of drugs. He said that during the afternoon of 5 October, he spent some time talking with Mr Chambers in his cell. He said that he and other prisoners were shocked when they learnt of his death.
56. Another prisoner who knew Mr Chambers, said he saw Mr Chambers when he was collecting his dinner and said Mr Chambers "...didn't look right, his eyes weren't right, and his head was sweaty." When he asked Mr Chambers if he was okay, he said he was.
57. At 5.09pm, an officer carried out a roll check. At 7.19pm, an officer noted in the ACCT document that he had checked Mr Chambers who was lying on his bed watching television. However, the CCTV shows that the officer did not check Mr Chambers at this time.
58. An Operational Support Grade (OSG) said that when she arrived on the wing at around 8.15pm, two officers gave her a handover but did not raise any issues about Mr Chambers, other than that he was being monitored under ACCT procedures.
59. At 8.52pm, an OSG checked Mr Chambers. She noted in the ACCT document that he was lying on his right side and she noted "movement".
60. At 12.33am on 6 October, an OSG checked Mr Chambers. She noted that he was lying on his left side and that she had seen him move. At 2.40am, the OSG checked Mr Chambers again, noting "movement" and that he was lying on his back. (This was the last time that staff noted a change in Mr Chambers' position.)
61. At 5.37am, an OSG carried out a further ACCT check while carrying out the early morning roll check. An OSG wrote an entry in the ACCT document on her behalf, noting that she had seen Mr Chambers lying on his back and that she had seen him move.
62. Both OSG's left the wing at around 7.15am. An officer, the early start officer on H wing, signed Mr Chambers' ACCT to confirm that responsibility for his checks had been handed to her from the night officers. However, she did not check on Mr Chambers.
63. At 8.41am, an officer unlocked Mr Chambers' cell. The officer went into the cell and found Mr Chambers lying in his bed, unresponsive. The officer said that it was clear from Mr Chambers' appearance that he had died. The officer called a medical emergency code blue (which indicates that a prisoner is unconscious or having difficulties breathing) and an ambulance was called.
64. An officer and a SO arrived at the cell a minute later and agreed with the officer's conclusion that Mr Chambers had died. At 8.43am, a nurse arrived at the cell and noted the presence of rigor mortis. She did not therefore try to resuscitate Mr Chambers. At 9.09am, paramedics arrived and confirmed that Mr Chambers had

died. When she left the cell, the nurse saw what she said appeared to be a “wick” with a burnt end in the toilet.

65. Police attended and removed several items from Mr Chambers’ cell, including a milk carton fashioned into a bong (a device for smoking drugs), half a white tablet and half an orange tablet, paper containing a green substance (thought to be PS) and a razor blade that had been fashioned into a weapon. (Humberside Police said no tests were conducted on the substances removed from the cell.)
66. Several intelligence reports were submitted after Mr Chambers’ death. One reported that a prisoner was heard to say, “I got him to test some and it appears strong.” It is not known who the prisoner was referring to. Humber passed the information to the police.
67. Another prisoner told staff that there was “green” (a reference to cannabis or PS) on the wing, and that he could not understand why people were still buying it after what had happened to Mr Chambers. Another prisoner told staff that there were a lot of drugs on the wing, including blue tablets with the letters “MSJ” written on them.
68. On 7 October, a prisoner told staff during a disciplinary hearing that he had brought PS into the prison the previous week and said that he believed that Mr Chambers had taken a concoction of drugs, including valium.
69. A SO told the investigator that after Mr Chambers’ death, he had heard from colleagues that some had “observed him perhaps on the verge of being under the influence”.

### **Contact with Mr Chambers’ family**

70. The Deputy Governor of Humber, and a family liaison officer, broke the news of Mr Chambers’ death to his family later that morning. Humber contributed to the costs of Mr Chambers’ funeral in line with national instructions.

### **Support for prisoners and staff**

71. The Head of Operations 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 them support. Notices to staff and prisoners were issued, telling them of Mr Chambers’ death.

### **Post-mortem report**

72. A post-mortem examination found that Mr Chambers had died of synthetic cannabinoid (PS) toxicity.
73. Post-mortem toxicology results established that Mr Chambers had also low concentrations of the drugs olanzapine (an antipsychotic) and mirtazapine (an antidepressant) in his system, but that these were below therapeutic levels.

# Findings

## Availability of illicit substances at Humber

74. Mr Chambers had a significant history of substance misuse, including PS. During his time at Humber there was no intelligence that he was using drugs. However, at an ACCT review, he was reported to have had slurred speech, and after his death, it was reported that he had been taking drugs in prison. Officers had also reported that they had seen Mr Chambers on the “verge of being under the influence”.
75. HM Inspectorate of Prisons reported that two thirds of prisoners said that it was easy to get drugs at Humber and that a third of prisoners said that they had developed a drug habit at the prison.
76. Humber has a Substance Misuse and Supply Reduction Strategy which was published in August 2017. The prison holds monthly drug strategy and PS meetings. The substance misuse strategy aims to give clear direction on how the prison should tackle substance misuse by reducing demand and supply, and by promoting recovery for prisoners through clinical intervention, education, motivation and support while managing safety and harm prevention.
77. The PPO’s Learning Lessons Bulletin on PS, issued in July 2015, highlighted that PS was even then a source of increasing concern in prisons and that its use had a profoundly negative impact on physical and mental health. Mr Chambers’ death is a clear example of how dangerous PS is and illustrates why prisons must do all they can to eradicate its use.
78. Although Humber had a sound local drugs strategy, drugs continued to be available in October 2018, and Mr Chambers apparently had no difficulty in obtaining and using drugs without staff becoming aware of it. We raised similar concerns about the availability of drugs at Humber in our report into the death of a prisoner there in February 2018. It is clear that the prison needs to do more to reduce both the demand and supply of drugs.
79. Drug taking and trading is a serious problem across much of the prison estate and Humber is not alone in facing this problem. In April 2019, HMPPS published a National Drug Strategy setting out their plans to reduce substance misuse by sharing best practice and providing direction and detailed guidance for prisons. In relation to reducing the supply of drugs, the new Prison Service strategy says:

“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.”

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 kept under review to ensure that these key issues are being addressed.**

## **Mr Chambers' use of illicit drugs**

80. The substance misuse team at Humber appropriately offered Mr Chambers support. When he declined to work with the team, he was reminded of the dangers of taking illicit drugs in prison, which he said he understood. However, it is evident that despite advice to the contrary, Mr Chambers continued to use drugs at the prison.

## **Reporting of prisoners under the influence**

81. Officers at Humber are expected to complete an intelligence report for a prisoner suspected of being under the influence of illicit substances.
82. On 19 September, a nurse asked a SO about Mr Chambers' slurred speech, but the SO assured her that Mr Chambers normally spoke that way. No other officers told us that Mr Chambers' speech was normally slurred. A SO told the investigator that after Mr Chambers' death, colleagues had told him that they had seen him on the "verge of being under the influence". Despite Mr Chambers' appearance on these occasions, staff never submitted an intelligence report as they should have done.
83. Intelligence provides vital evidence in identifying prisoners involved in prison drug culture and can support intelligence-led cell searches and suspicion drug testing of prisoners, both tools used to disrupt the supply and demand for drugs in prisons. It is critical that any evidence identifying prisoners' use or supply of drugs is recorded and reported to the prison's security department. We make the following recommendation:

**The Governor should ensure that all staff complete an intelligence report when a prisoner is thought to be under the influence of illicit drugs or involved in the prison's drug culture.**

## **Substance Misuse and Supply Reduction Strategy training**

84. Contrary to Humber's substance misuse and supply reduction strategy, not all the staff we spoke to were aware of the strategy or had received recent drug awareness training. We make the following recommendation:

**The Governor should ensure that all staff are aware of the local substance misuse and supply reduction strategy and receive drug awareness training.**

## **Staff observations on 5/6 October**

85. PSI 64/2011 on safer custody sets out how prisoners considered at risk of suicide or self-harm should be supported and managed. Mr Chambers was being

monitored under ACCT procedures at the time of his death and for the most part, procedures were appropriately followed, and he was supported by staff.

86. However, it became apparent during our investigation, that staff did not complete ACCT observations and roll checks to a satisfactory standard on the evening of 5 October and the morning of 6 October.
87. At 7.19pm, an officer noted in the ACCT document that he had checked Mr Chambers when he had not done so. After Mr Chambers' death, the officer admitted that he had not carried out the check as he should have done.
88. We also note that CCTV shows that an officer's ACCT check at 5.09pm, an OSG's check at 5.37am and an OSG's check at 8.52pm were distant and cursory. Although an OSG told us that she had seen Mr Chambers move at 5.37am, we are not satisfied that her check lasted long enough for her to have observed this.
89. We are also concerned that when an OSG carried out the early morning roll check at 5.37am, she combined this with Mr Chambers' ACCT check, which was inappropriate. In addition, although an officer noted in the ACCT document that she had completed the 5.37am check and seen Mr Chambers move, it was in fact another officer who had completed the check. OSGs should write their own entries in ACCT documents and not rely on their colleagues to do so.
90. The Governor of Humber carried out an investigation into the actions of the officers we have identified as failing to carry out their duties satisfactorily. This concluded in January 2019 and Humber told us that disciplinary action was taken.
91. We also note that when an officer took over from the night staff, she did not complete an ACCT check for Mr Chambers, as she should have done.
92. Although we cannot be sure when Mr Chambers died, we know that he had been dead for some time when he was found at 8.41am as rigor mortis was present. It is likely that he died sometime after 2.40am, after which time staff did not see him move. We are not satisfied that the ACCT and roll checks were carried out to the standard expected that morning. Although we cannot know whether a more thorough completion of these checks would have affected the outcome for Mr Chambers, they might have done. We make the following recommendations:

**The Governor should ensure that:**

- **staff completing, roll checks, welfare checks, or ACCT checks satisfy themselves that there are no immediate causes for concern: and**
- **officers should record their own checks on the appropriate documents.**

## **Clinical review**

93. The clinical reviewer concluded that the clinical care that Mr Chambers received at Humber was of a satisfactory standard and equivalent to that which he could have expected to receive in the community.

94. However, the clinical reviewer made two recommendations which the Head of Healthcare will need to address. The first related to a delay in Mr Chambers receiving a mental health assessment after he was transferred to Humber, and the second was about the need for the medical needs of prisoners transferring between prisons to be effectively communicated.

**Prisons &  
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