Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Henry Ballantyne, a prisoner at HMP Kirklevington Grange, on 28 January 2021

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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

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 Henry Ballantyne was found hanged in his room at HMP Kirklevington Grange on 28 January 2021. He was 34 years old. I offer my condolences to Mr Ballantyne's family and friends.

Mr Ballantyne, who was serving a life sentence, had entered prison for the first time at the age of 20 and had been in prison for over 13 years. He had made good progress through the prison system and was on track to be released in 2021, subject to Parole Board approval. It appears that Mr Ballantyne was struggling with the prospect of release far more than anyone realised. Although friends detected a slight shift in Mr Ballantyne's behaviour as he neared potential release, I am content that he did not give staff any cause for concern and that they could not have foreseen his actions.

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 October 2007, Mr Henry Ballantyne was sentenced to life imprisonment for murder, with a minimum term of 13 years and six months.

2. Mr Ballantyne's progression through the prison system was relatively smooth and in June 2018, he moved to open conditions at HMP Kirklevington Grange.

3. Mr Ballantyne experienced several bereavements in 2018 and undertook counselling. He stopped the sessions after six months as he said he no longer needed them.

4. In October 2020, Mr Ballantyne's brother died but he said he did not need any help to cope with this. He was working, had a girlfriend and was likely to be released in the spring of 2021.

5. Prisoner friends said that they had noticed a slight dip in Mr Ballantyne's mood as his parole hearing neared, but there is nothing in the records to suggest staff should have had any concerns about him. The evening before his death, he was busy writing letters but did not tell friends or staff that anything was worrying him.

6. In the early hours of 28 January 2021, a prisoner went to wake Mr Ballantyne for work. When he could not rouse Mr Ballantyne, he alerted an officer who discovered Mr Ballantyne hanging from the window. He was clearly dead so staff did not try to resuscitate him. Paramedics arrived and declared Mr Ballantyne's death at 5.09am.

Findings

7. Mr Ballantyne did not display any obvious signs to staff that he was struggling mentally. We are satisfied that staff could not have foreseen his actions.

8. Mr Ballantyne was mistakenly sent victim statements in his parole dossier in September 2020, and there is some evidence they upset him. We cannot say whether this contributed to his decision to take his life four months later, but it should not have happened.

9. The clinical reviewer found that the standard of mental health care Mr Ballantyne received at Kirklevington Grange was generally good and was equivalent to that he could have expected to receive in the community.

10. The prison's clocks were inaccurate which meant that their records of the timings of the emergency response differed to the Ambulance Service's records. It is important that prison clocks show the correct time.

Recommendations

- The Governor should ensure that parole dossiers are checked and victim statements are removed before dossiers are sent to prisoners.

- The Governor should ensure that key establishment clocks are accurate.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Kirklevington Grange informing them of the investigation and asking anyone with relevant information to contact her.

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

13. The investigator interviewed eight members of staff and one prisoner in March 2021. NHS England commissioned an independent clinical reviewer to review Mr Ballantyne's clinical care at the prison. The investigator and clinical reviewer jointly interviewed healthcare staff. Due to coronavirus restrictions, all interviews were conducted by telephone.

14. We informed HM Coroner for Teesside of the investigation. He gave us the result of the post-mortem examination. We have sent the coroner a copy of this report.

15. One of the Ombudsman's family liaison officers contacted Mr Ballantyne's next of kin, his aunt, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not raise any concerns but asked to see a copy of our report.

16. Mr Ballantyne's next of kin received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.

17. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out one factual inaccuracy and amendments have been made to this report.

Background Information

HMP Kirklevington Grange

18. HMP & YOI Kirklevington Grange is an open prison holding up to 283 Category D adult male prisoners and young male offenders. Healthcare services are delivered by several providers. G4S Health Services (UK) Limited delivers primary nursing and administration services; Spectrum Community Health CIC provide GP and pharmacy services; Tees, Esk and Wear Valleys NHS Foundation Trust deliver mental health services; Change, Grow, Live (CGL) provide psychosocial substance misuse services; and G4S provide clinical Substance misuse services.

HM Inspectorate of Prisons

19. HM Inspectorate of Prisons (HMIP) last carried out an inspection of Kirklevington Grange in August 2019. Inspectors noted that the prison had continued to deliver good outcomes against their healthy prison tests. They considered it an overwhelmingly safe and respectful facility. They identified that more needed to be done to get prisoners into paid work in the community.

20. The complex network of healthcare providers meant there had been some communication issues, but any local governance problems were addressed during the inspection. Prisoners were complimentary about the healthcare services they received.

Independent Monitoring Board

21. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 31 December 2019, the Board noted that the prison was well run, and most prisoners were positive about their experience. Healthcare facilities had improved, and the prison had put in place a comprehensive delivery plan to improve the environment and release preparation.

Previous deaths at HMP Kirklevington Grange

22. There were no deaths at Kirklevington Grange in the two years prior to Mr Ballantyne's death.

Key Events

23. On 19 October 2007, Mr Henry Ballantyne was sentenced to life imprisonment for murder with a minimum term of 13 years and six months. He was 20 years old and it was his first time in prison.

24. When Mr Ballantyne arrived in prison, staff started suicide and self-harm monitoring (known as ACCT) as they were concerned about how Mr Ballantyne had responded to his sentence: he was low in mood and seemed shocked. He was also missing his family and it was noted how close he was to his mother. Staff stopped ACCT monitoring after one week once Mr Ballantyne's mood had improved. This was the only time ACCT procedures were used to manage Mr Ballantyne.

25. Mr Ballantyne's time in custody was mostly uneventful (just one adjudication in 2008), and he participated well in the many courses that were part of his sentence plan. In March 2018, the Parole Board agreed that Mr Ballantyne was suitable for open conditions.

26. On 5 June, Mr Ballantyne was moved to HMP Kirklevington Grange. He integrated well at the prison, he got on with staff and other prisoners and he held down a number of jobs. He gave a talk to children at a local school about his experience of prison.

27. In the first six months of 2018, three of Mr Ballantyne's family members died in quick succession (his cousin, his grandmother and, crucially, his mother). His father had died some years before.

28. In January 2019, Mr Ballantyne started counselling to help him come to terms with his losses. He stopped the sessions in June 2019 as he said he did not need them anymore. There is no evidence to suggest his counsellor (who has since left Kirklevington Grange) disagreed.

29. In September 2020, Mr Ballantyne was sent his parole dossier. A prisoner friend told the investigator that Mr Ballantyne had said the dossier contained victim statements which had upset him. The Head of Offender Management Delivery at Kirklevington Grange told the investigator that records indicated that the dossier did contain victim statements and they should not have been included.

30. In October 2020, Mr Ballantyne's offender supervisor noted that he had started a relationship with an acquaintance of his sister. He had also recently got a job outside the prison which he really enjoyed.

31. On 19 October, Mr Ballantyne was told that his brother had died. He was found under a bridge, but we do not know the cause of death. Mr Ballantyne told staff he was being supported by his family and that he was 'okay'. He decided not to go to the funeral although he had permission for this.

32. On 26 October, a pharmacy technician carried out a medication in possession assessment. Since the onset of the COVID-19 pandemic, the service had redesigned how it carried out such assessments, which had previously been done face to face. To limit infections, assessments were carried out with prisoners over the phone. However, the pharmacy technician did not speak to Mr Ballantyne at all and just took information from his medical notes. She recorded that he had not

recently experienced any significant life changing events (even though his brother had died a week before).

33. Mr Ballantyne's offender supervisor and his personal officer (since July 2020) spoke to Mr Ballantyne regularly and made comprehensive entries in his prison record about their conversations.

34. Mr Ballantyne had a parole hearing booked for 30 March 2021 and the Probation Service supported his release. Everything seemed to be going well in advance of it. An assessment was going to be carried out at his aunt's property to determine if it was a suitable release address.

35. On 15 January 2021, Mr Ballantyne's offender supervisor, along with Mr Ballantyne's offender manager, spoke to Mr Ballantyne. She noted that Mr Ballantyne seemed a little anxious that his offender manager was leaving and that a new one would be attending his parole hearing, but they reassured him. Mr Ballantyne's offender supervisor noted that Mr Ballantyne continued to do well in his job and hoped to continue working there after his release. Mr Ballantyne talked about his brother's death and said the counselling he had previously received, and the techniques he had learned when his mother died, had really helped him. He reported no problems.

36. On 24 January, Mr Ballantyne's personal officer noted that he had spoken to Mr Ballantyne while he was exercising. Mr Ballantyne had said that he was doing well and had no issues.

37. After Mr Ballantyne's death, a prisoner and friend of Mr Ballantyne's wrote a statement which said that there was a notable shift in Mr Ballantyne's behaviour from the time when release became likely. He said that Mr Ballantyne had always talked about getting his parole but as soon as he received his parole dossier, he did not mention it again. He said Mr Ballantyne was anxious about getting any negative entries on his record that could change things. He was also worried about his solicitor and offender manager changing and he believed he had a drugs charge from years ago still pending. In his friend's opinion, Mr Ballantyne was not as sociable as he had been.

38. Another prisoner said he thought that Mr Ballantyne was paranoid about getting into any kind of trouble that might jeopardise his parole and that he was concerned about solicitor costs.

27 January 2021

39. On 27 January, at approximately 7.00pm, a prisoner saw Mr Ballantyne writing in his room. He also saw Mr Ballantyne writing and asked him what he was doing. Mr Ballantyne said it was nothing to do with him. The prisoner knew Mr Ballantyne had been making lots of notes for his parole and he asked him if he was alright. Mr Ballantyne said he was. He also asked another prisoner if he thought Mr Ballantyne was alright and he said that he thought he was.

40. At 8.00pm, an officer did the roll check. He did not know Mr Ballantyne and he does not specifically recall checking Mr Ballantyne's room or speaking to him at any other point that evening.

41. Between 9.00pm and 10.00pm, a prisoner heard Mr Ballantyne talking on the phone. He presumed Mr Ballantyne was talking to his girlfriend who he usually rang at that time. He did not recall anything unusual.

42. Several prisoners have told staff that they thought Mr Ballantyne had acted strangely in the lead up to his death – that he had been quiet at work, had given away a computer game, ordered sweets from the canteen which was unusual for him and had at times just stood around aimlessly, not speaking to anyone or with any real purpose. However, he also showed evidence of forward planning, having promised to cook another prisoner a curry that coming Saturday.

28 January 2021

43. At some point after 4.30am on 28 January, a prisoner knocked on Mr Ballantyne's door to get him up for work. He did not answer. The prisoner went to the bathroom area and asked another prisoner to try and rouse him. The other prisoner knocked on Mr Ballantyne's door and called his name, but there was no response. He went to fetch an officer who attended immediately.

44. The officer knocked on the door but got no response so he went into the room. He could not see Mr Ballantyne in his bed which had been made. He turned the light on and saw Mr Ballantyne slumped on the floor by the window. A dressing gown cord was tied around his neck with the other end tied to the window bar.

45. At 4.45am, the officer called a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties) over his radio and went to take the weight off Mr Ballantyne and cut the ligature with his cut down tool. The officer asked one of the prisoners to sound the general alarm and the prisoner did this.

46. An Operational Support Grade (OSG) was in the control room with a Supervising Officer (SO) who told him to call an ambulance. The OSG did so at 4.45am according to his log (but 4.51am according to the ambulance log). The OSG told the investigator that the clock in the control room was inaccurate and that he had definitely not delayed calling the ambulance.

47. Mr Ballantyne was cold to the officer's touch, had no pulse and the tip of his tongue was dark blue. A SO and an officer arrived at the scene. The SO saw that Mr Ballantyne was not breathing, his left arm was rigid, and his fingers were bent inwards and fully extended. Staff assessed that Mr Ballantyne was already dead and did not try to resuscitate him.

48. Paramedics arrived at the prison at 4.58am and were escorted to the unit. They noted that Mr Ballantyne had no pulse and his neck was broken. They certified death at 5.09am.

49. Staff found three notes at the scene from Mr Ballantyne to his aunt, his sisters and his partner. He explained that he had not recovered from the deaths of his mother and others and that he found the prospect of release scary without his mother around. He did not think he was a good enough partner for his girlfriend or brother to his sisters.

50. The PPO has also been made aware that Mr Ballantyne was in touch with the Samaritans and while they were very upset to hear the news of his death, they were not surprised. Because of the confidential nature of their work, they are unable to discuss the details of their conversations with Mr Ballantyne.

Contact with Mr Ballantyne's family

51. The prison appointed a SO as the family liaison officer at 5.50am and the next of kin was told of Mr Ballantyne's death the same day. The prison contributed to funeral costs in line with national policy.

Support for prisoners and staff

52. On 28 January, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

53. The prison posted notices informing other prisoners of Mr Ballantyne's death and offering support.

Post-mortem report

54. The post-mortem report concluded that Mr Ballantyne died from pressure on the neck caused by hanging.

Findings

Management of Mr Ballantyne's risk of suicide and self-harm

55. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), provides guidance to staff on how to identify prisoners who might be at risk of suicide and self-harm and sets out the procedures (known as ACCT) that should be followed.

56. We consider that Mr Ballantyne gave staff no cause for concern that would have merited staff starting ACCT procedures. He spoke regularly with his personal officer and his offender supervisor, expressing only minor anxieties to the latter. He was well liked by staff and other prisoners, and probation were supporting his release, with the parole hearing scheduled for the end of March 2021.

57. Mr Ballantyne's friends detected a slight shift in his behaviour as his parole date neared, but it was not significant and prisoner anxieties about being released after serving a long sentence are common. It is clear from the notes Mr Ballantyne left, that his concerns ran deeper than anyone suspected, that he doubted he could cope on the outside without his mother and that he did not think he deserved to be released.

58. We are satisfied, however, that he gave little indication of his fears to staff and that they could not have foreseen his actions.

Victim statements

59. We are concerned that victim statements were mistakenly included in the parole dossier sent to Mr Ballantyne in September 2020. There is some evidence that they upset him. This was four months before Mr Ballantyne died and we cannot say whether this contributed to his decision to take his life, but it should not have happened. We recommend:

    The Governor should ensure that parole dossiers are checked and victim statements are removed before dossiers are sent to prisoners.

Clinical care

60. The clinical reviewer concluded that the clinical care Mr Ballantyne received was generally of a good standard and equivalent to that he could have expected to receive in the community. The clinical reviewer found that Mr Ballantyne received proactive, responsive care from mental health services at Kirklevington Grange.

61. The clinical reviewer noted that the medication in possession assessment carried out by the pharmacy technician on 26 October 2020, consisted only of a review of Mr Ballantyne's medical record and she did not speak to him by telephone as she should have done. She recorded that Mr Ballantyne had not recently experienced any life-changing events, although his brother had died the week before. If she had spoken to Mr Ballantyne, it is likely that he would have told her this and there would have been an opportunity to offer support.

62. The Head of Healthcare told the investigator that an investigation was being conducted into the pharmacy technician's actions which may lead to disciplinary action.

63. The medication in possession assessment took place three months before Mr Ballantyne's death. While it was not carried out as it should have been, it is unlikely that this oversight contributed to Mr Ballantyne's death. Given this, and that an investigation has already been commissioned by the prison, we make no recommendation.

Emergency response

64. The control room log indicates that an ambulance was called at 4.45am but the ambulance service record says they received the call at 4.51am. The investigator spoke to the OSG and SO who were in the control room. The OSG said he did not delay calling the ambulance and the SO, who left the room to attend the scene, was not aware of any delay either. The OSG said that he went by the clock on the wall but that he thought it was inaccurate. The SO said there are in fact two clocks and that they are often not accurately synched.

65. It is important that times can be accurately logged and we make the following recommendation:

The Governor should ensure that key establishment clocks are accurate.

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