Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Lee Scott, a prisoner at HMP Humber, on 14 June 2022

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

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 Lee Scott died after he was found hanged in his cell at HMP Humber on 14 June 2022. He was 47 years old. I offer my condolences to Mr Scott's family and friends.

Mr Scott had spent almost all his adult life in prison and found it difficult to cope in the community. Mr Scott felt disappointed about the lack of progression opportunities when he arrived, which was due to staffing shortages and COVID-19 restrictions. He was frustrated about the amount of time he was spending in his cell and without employment and the impact on his progression.

We are concerned about the staffing shortages at Humber and the impact on the prison's ability to run a meaningful regime and progression activities during Mr Scott's time there. This resulted in him spending most of his time in his cell and only being offered one key work session in a four-month period. Up until May 2022, an Exceptional Delivery Model (EDM) was in place for regime activities including key work, due to the COVID-19 pandemic. This significantly reduced opportunities for meaningful contact, which impacted on Mr Scott. We recognise that this was outside the Governor's control, however the shortages affected key parts of the regime that increase safety for prisoners. It is therefore important that the Director General for Prisons considers how prisons can reasonably deliver a safe and decent regime and deliver key work in these circumstances.

We found some delays in the emergency response when staff found Mr Scott in his cell. This did not affect the outcome for Mr Scott but may make a difference in a future emergency and should be addressed.

The clinical reviewer concluded that Mr Scott's clinical care was of a good standard and therefore equivalent to that which he could have expected to receive in the community.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Kimberley Bingham
Acting Prisons and Probation Ombudsman **June 2023**

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Summary

Events

1. Mr Scott was serving a life sentence for murder. He had been released for two short periods in 2017 and 2020 but found it difficult to cope with life in the community and was recalled after breaking his licence conditions.

2. In 2015 and 2020, Mr Scott told staff that he had nothing left to live for and they put additional monitoring in place under ACCT procedures.

3. In February 2022, Mr Scott was transferred to the Hope Unit at HMP Humber, which had been relocated to a different part of the prison due to refurbishments. He told staff that he had no thoughts of suicide or self-harm and a mental health nurse concluded he did not need further mental health support.

4. Mr Scott engaged with a range of prison staff during his time at Humber. He opened up about the impact of childhood trauma on his life, and the issues he had experienced in the criminal justice system. He spoke to staff about preparing for his next parole review.

5. On 7 May, Mr Scott told his aunt that he had had suicidal thoughts and said that he had nothing to live for. Staff had no reason to monitor his calls so did not pick up on this.

6. On 10 June, Mr Scott told a friend that he was going to apply for release at his next parole review. They discussed her serious illness. On 12 June, Mr Scott telephoned his aunt and told her that he was worried about how long his friend had left to live. He was also frustrated that he did not have a job in prison, which meant that he spent a lot of time in his cell. That day, Mr Scott told his friend that he wanted to make memories in the community.

7. Over time, Mr Scott had become frustrated about the lack of opportunities to progress his sentence at Humber and shared his concerns with staff on 13 June. That day, he was told that he would have to share a cell when prisoners moved back to the Hope Unit. Mr Scott was reluctant to do so because of previous experiences with cellmates in other prisons. That evening, Mr Scott spoke to his friend again, on the telephone. He was unhappy about having to share a cell but said he would try it. He spoke about his plans for release again.

8. On 14 June at 5.35am, an operational support grade (OSG) checked on Mr Scott. He had blocked his cell door observation panel and did not respond. The OSG became concerned and telephoned for staff assistance while checking on other prisoners. He returned to Mr Scott's cell three minutes later. When the OSG looked through the crack of the cell door, he saw Mr Scott hanging. He called an emergency code and waited for other officers to arrive before going into the cell. Officers cut Mr Scott down but did not try to resuscitate him when they saw signs that he was dead. Paramedics arrived and confirmed that Mr Scott had died.

Findings

9. Mr Scott was frustrated about the amount of time he was spending in his cell and without employment due to COVID-19 restrictions and wider staff shortages. For a period of time, he was worried about the prospect of sharing a cell. However, he engaged with staff, completed a form requesting consideration of his release and talked about his progression in prison. A few weeks before his death, Mr Scott shared information with family and friends by telephone about his lack of sleep and deteriorating mental health. Prison staff were not aware of this and did not observe any signs that he posed a risk to himself. In the same calls, he shared plans for release.

10. During the four months that Mr Scott spent at Humber, he was offered only two key worker sessions. One of the sessions was cut short because the officer had to attend other duties, and no notes were recorded. The Governor told the investigator that due to staff vacancies, the temporary relocation of the unit, COVID-19 restrictions, a COVID-19 outbreak and staff sick leave due to COVID-19, key work was not taking place as it should have. This was due to the Exceptional Delivery Model (EDM) in place due to the COVID-19 pandemic.

11. When the OSG went to Mr Scott's cell, his cell door observation panel was covered. He did not challenge this or try to look through the crack in the door. Once he did so, three minutes later, he waited for staff to arrive before going into Mr Scott's cell. The OSG told us that this was because he knew that Mr Scott was dead. There was a delay of at least three minutes in calling the ambulance and control room staff initially directed response staff to the wrong wing.

12. The clinical reviewer found that the clinical care that Mr Scott received was of a good standard and equivalent to that which he could have expected to receive in the community.

Recommendations

- The Director General of Prisons and MoJ People Group should consider what additional support can be put in place to address staffing shortages at Humber and consider how it can reasonably deliver a meaningful regime and deliver key work in these circumstances.

- The Governor should ensure that staff respond appropriately to blocked observation panels to ensure the security and safety of prisoners, and that managers support staff to enforce this**.**

- The Governor should remind staff that, subject to a risk assessment, they should enter cells as quickly as possible if there is reason to consider that a prisoner may be at risk.

- The Governor should ensure that control room staff accurately communicate the location of an incident and request an ambulance as soon as an emergency code is radioed.

The Investigation Process

13. 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. One prisoner responded. The investigator interviewed him, and another prisoner, by telephone on 27 June 2022.

14. The investigator obtained copies of relevant extracts from Mr Scott's prison and medical records. The investigation was then reallocated to another investigator.

15. NHS England commissioned a clinical reviewer to review Mr Scott's clinical care at the prison. The clinical reviewer and investigator jointly interviewed six members of staff.

16. We informed HM Coroner for Hull and the East Riding of Yorkshire of the investigation. He shared Mr Scott's post-mortem report with us. We have sent him a copy of this report.

17. The Ombudsman's family liaison officer contacted Mr Scott's parents and his father's cousin to explain the investigation and to ask if they had any matters they wanted us to consider. Despite several attempts by telephone, post and email, the FLO was unable to contact Mr Scott's family.

18. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly. The action plan has been annexed to this report.

Background Information

HMP Humber

19. HMP Humber is a category C prison that holds up to 1,062 men. City Health Care Partnership provides healthcare services from 7.00am to 8.30pm and there is no healthcare service during the night.

20. The Hope Unit is one of four 'progression regimes' in England for indeterminate sentenced prisoners, including those serving life sentences, who have been excluded from open prisons. The unit provides additional support to prisoners who need to demonstrate to the Parole Board that their risk has reduced, and reintroduces the responsibilities, tasks and routines associated with daily life in the community, to test readiness for release. Progression regimes are made up of three stages of progression and use the Enhanced Behaviour Monitoring (EBM) process used in open and women's prisons to provide consistent risk monitoring. Every three months, prisoners will be considered by an EBM Board, who will decide whether they can move to the next stage of the regime.

21. The Hope Unit is usually based on G Wing, but due to refurbishments, prisoners lived on D Wing in the first few months of 2022. They were due to return to G Wing the weekend after Mr Scott died.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Humber was in October and November 2020. Inspectors reported that prison staff had introduced measures to prevent self-harm, including well-being checks, to identify individual risks and vulnerabilities.

23. At the time of the inspection, HMIP found that fewer than half of prisoners said that a member of staff had spoken to them in the past week about how they were getting on. They recorded that there was a lack of continuity of officers who conducted wellbeing checks and they did not reflect the purposeful contacts that the key worker scheme was designed to provide.

Independent Monitoring Board

24. 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 December 2021, the IMB reported that levels of violence, bullying and self-harm remained low at Humber. They identified that the effectiveness of the key worker scheme had been compromised due to the impact of the COVID-19 pandemic and urged the Governor to prioritise re-establishing the scheme.

Previous deaths at HMP Humber

25. Mr Scott is the eighth prisoner to die at Humber since June 2020, and the first to take his own life during this period. There are no significant similarities between our

investigation findings into Mr Scott's death and the findings for previous investigations.

Assessment, Care in Custody and Teamwork

26. 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. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner.

27. As part of the process, a care plan (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the care plan have been completed. 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. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key worker scheme

28. The key worker scheme provides prisoners with an allocator officer that they can meet regularly to discuss how they are and any day-to-day issues they would like to address. Improving safety is a key aim of the scheme. All adult male prisoners should have around 45 minutes of key work each week, including a meaningful conversation with their allocated officer.

Key Events

Background

29. In March 1992, at the age of 17, Mr Lee Scott was remanded in custody after being charged with murder. He was given a life sentence the following year, with a minimum tariff to serve of ten years.

30. When he was first sent to prison, Mr Scott said that he had cut his wrists. In October 2015, staff monitored him under ACCT procedures for a week when he was refused parole and said that he would harm himself. No other instances of suicidal ideation or self-harm are recorded.

31. Mr Scott was prescribed antidepressants for number of years but chose to end his prescription in 2012. He had a history of substance misuse and had taken drugs on a few occasions in prison but engaged well with substance misuse services.

32. In 2017 and 2020, Mr Scott was released on licence for short periods and later recalled to custody.

33. On 20 February 2020, Mr Scott was transferred to HMP Lindholme. He told staff that he had been struggling with anxiety and depression and they referred him to the mental health team. On 1 March, a mental health nurse assessed Mr Scott, recorded that he did not have an acute mental disorder and discharged him from the mental health team's caseload.

34. On 16 March, Mr Scott said that he had "nothing to live for" and he was monitored by ACCT procedures for four days. In September 2020, the Parole Board requested a psychological assessment for Mr Scott to consider his sentence progression. The assessment was completed in December and concluded that Mr Scott found it difficult to cope in the community due to the length of time that he had been in prison. It recommended that Mr Scott should progress to open conditions so that he could more effectively prepare for release.

35. On 29 April 2021, the Parole Board agreed that Mr Scott should progress to open prison. However, the Secretary of State did not support the decision and concluded that Mr Scott should remain in closed conditions for a further 18 months. The letter noted that Mr Scott's next parole review would start in April 2022 and the target for the decision was October 2022.

36. Mr Scott appeared to settle at Lindholme, with only three security incidents recorded. However, in June 2021, staff found Mr Scott under the influence of drugs. Later that month, they found medication in his shared cell that neither he nor his cellmate had been prescribed.

37. In August, Mr Scott had a meeting with his Prison Offender Manager (POM), and his Community Offender Manager (COM). They advised him to consider moving to the Hope Unit at HMP Humber, which could support him in preparing for his next parole review. He said that he had used drugs once recently. He also said that he had had enough of being in prison but was still worried about how he would manage in the community when released. Staff explained that the Hope Unit was

designed to address his concerns. In November, Mr Scott confirmed that he wanted to move to the Hope Unit and staff made the appropriate referral.

38. In December, Mr Scott told his POM that his mother had asked him not to contact her again, which had been upsetting for him.

39. Later that month, prison staff found illicit alcohol in Mr Scott's shared cell. That day, he indicated that he had been pressured into holding illicit items by other prisoners.

HMP Humber

40. On 28 February 2022, Mr Scott was transferred to HMP Humber. He moved into a single cell on H Wing and began a period of isolation in line with national COVID-19 guidelines. A nurse assessed Mr Scott when he arrived. Mr Scott told him about his history of substance misuse but said that he had no issues with substances at the time. He said that he had no thoughts of suicide and self-harm.

41. A nurse completed a mental health screen for Mr Scott, which was a standard process for all new arrivals at Humber. Mr Scott said that he had cut his wrists over 30 years ago but had no active thoughts of suicide or self-harm. He also said that he had not had any support in the community when he had been released on licence. Mr Scott concluded that he did not need mental health support in prison and the nurse did not refer him to the mental health team. The nurse told the investigator that Mr Scott seemed focussed on the future and appeared to be well overall.

42. During his first night interview with a prison officer, Mr Scott raised no concerns and said that all of his needs had been met. He said he had no mental health or substance misuse issues and that he had no thoughts of suicide or self-harm.

43. On 2 March, a business administrator spoke to Mr Scott as part of a wellbeing check. She recorded that he did not have any immediate concerns but that he was struggling to adjust to his new environment at Humber. She noted that they discussed that Mr Scott would have to share a cell when he moved to the Hope Unit. Mr Scott said that he did not want to share due to issues that he had experienced in the past, including getting caught up in cellmates' illicit activities which he thought had affected his chances of parole. She recorded that she told Mr Scott that a positive part of the Hope Unit was that he would share a cell with someone in the same position as him. Mr Scott said that he would "give it a chance", and if it did not work out, he would ask to be transferred back to Lindholme.

44. On 15 March, Mr Scott completed his COVID-19 isolation and moved to the Hope Unit on D Wing. He was allocated a double cell in which he lived by himself. The Hope Unit's usual location was closed for refurbishment and prisoners had been relocated in the interim. A Custodial Manager (CM) said that at the time, prisoners had much less time out of their cells than they would usually have due to staffing shortages and the temporary relocation of the unit. (This meant that prisoners had to share exercise facilities with another wing, which meant that staff supervision was necessary.) At the time, prisoners had around three hours a day out of their cells.

45. On 22 March, Mr Scott's POM, introduced herself to him. They spoke about Mr Scott's difficult upbringing and he said that he had panic attacks. He said that he did not want to share a cell but she said that a single cell could not be guaranteed in the future. They spoke about his plans for release and the possibility of Mr Scott being released to a psychologically informed planned environment (PIPE) approved premises for additional support. (These approved premises are run by psychologists and have a therapeutic environment.)

46. On 12 April, an officer tried to hold an introductory key worker session with Mr Scott. He recorded that he visited Mr Scott twice but he was in bed on both occasions. The officer noted that Mr Scott turned over when he called his name but did not engage with him. No further key worker sessions are recorded.

47. On 15 April, the POM met Mr Scott. He spoke about feeling overwhelmed in the community when he was last released. On 22 April, she saw Mr Scott on the wing and he told her that he was not sleeping. He said that he had tried various remedies but nothing had worked. He said that he had added his name to the waiting list for the gym in the hope that it might help.

48. On 27 April, a trainee forensic psychologist spoke to Mr Scott about his childhood trauma and difficult relationship with his parents. She noted that Mr Scott understood how those factors had affected his self-esteem, emotional management and behaviour.

49. On 6 May, staff saw Mr Scott fighting with another prisoner. They stopped when asked. A nurse assessed Mr Scott for injuries and he said the other prisoner had grabbed him. The nurse noted that he had a slightly red neck but Mr Scott declined further assessment. An officer put Mr Scott on report (which meant that he would be subject to a disciplinary hearing about the incident). The security report noted that a Challenge Support and Intervention Plan (CSIP, used to support violent prisoners and prisoners at risk from others) would be opened but this was not actioned. The officer was on long-term sick leave at the time of writing and could not be interviewed.

50. On 7 May, Mr Scott rang his aunt and told her that he had been having thoughts of suicide for four days. He said that he could not sleep, was nervous, shaking, felt lonely and was finding things so difficult that he felt like giving up. He said that he spent all day locked in his cell, felt sick, had no money and had nothing to live for.

51. On 9 May, staff held a disciplinary hearing with Mr Scott about the fight that he had been involved in. Mr Scott said that they had disagreed over a vape and the other prisoner had pushed him so he held onto him. Mr Scott said that he was friends with the other prisoner, they remained on the same wing and it was "stupid really". Staff adjourned the hearing for 14 days to review the CCTV coverage of the incident. On 23 May, staff held a further hearing but noted that since the other prisoner had been released, the hearing could not be concluded. Documents noted that Mr Scott was usually polite and respectful.

52. On 11 May, Mr Scott attended his Enhanced Behaviour Monitoring (EBM) Board with the trainee forensic psychologist, his POM and a case administrator. He said that the unit was not meeting his expectations. Staff reassured Mr Scott that things should improve once he returned to the Hope Unit and as COVID-19 restrictions

were eased. Mr Scott acknowledged that he needed to work hard to secure his release and he had a good family network to support him. They discussed strategies for coping in the community and the factors which had led to his offending and recall and how they could be addressed. Staff noted that Mr Scott's key worker, The officer, had been unable to attend the meeting but had made a written contribution. She said that she had only met him once and that the session had been cut short as she had to leave to go elsewhere, but that Mr Scott had engaged well and considered what he needed to do when he was released. She acknowledged that she had not had the time to complete any work with him before the meeting.

53. The POM identified goals for Mr Scott to work on, including completing worksheets on problem solving, the challenges in moving back into the community and building a positive relationship with his key worker. Mr Scott said that he was happy to start working towards the goals but was disappointed that he had not yet got a job in the prison or been able to access the gym. She said that she would chase the requests for Mr Scott.

54. A prisoner lived in the cell opposite Mr Scott, and they got on well. The prisoner told us that Mr Scott liked having his own cell. He said that Mr Scott did not have any issues with drugs at Humber and they were hard to obtain on the Hope Unit because prisoners were keen to progress. He said that Mr Scott had never spoken to him about any feelings of suicide or self-harm. He also told us that Mr Scott had found his lack of employment difficult because it meant that he spent too much time in his cell and felt that he was not progressing. Another prisoner on D wing, told the investigator the same thing.

55. On 13 May, Mr Scott met his POM and they had a video conference with his COM. They discussed his difficulties with coping in the community. Mr Scott understood that he was in his parole review period. He said that he would not be recommended for release and recognised that he needed to focus on his progression and having a deeper level of reflection. They discussed the altercation with another prisoner and Mr Scott said that he was not worried about it. The disagreement was over vapes and the other prisoner had assaulted him as he walked away. The POM noted that Mr Scott had a bruise on his neck. Mr Scott said that he did not retaliate, that he had since shaken hands with the other prisoner and there were no further issues between them. She had witnessed them sitting at the same table without any problems and she had no concerns.

56. On 20 May, the POM spoke to Mr Scott who said that he had a neck ache. She advised him to ask to see a GP. She told the investigator that Mr Scott was still waiting to get a job so he spent a lot of time in his cell. She said that the Hope Unit was not running as the progression unit that it was designed to be and that staffing issues had limited employment opportunities.

57. On 31 May, Mr Scott received a copy of his parole dossier to help him prepare for his next review. The dossier contained information and assessments about his last parole decision in April 2021. It also contained a report from his previous POM at Lindholme, who recommended that he should remain in a closed prison and engage with the Hope Unit. The POM said the progression regime would help him to develop his skills and confidence and increase the likelihood of him being successfully released in the future. It also included a report from his COM, which

summarised Mr Scott's time in custody and the aims identified for him while on the Hope Unit. It outlined a resettlement plan for the community but recommended that Mr Scott should first complete work on the Hope Unit.

58. On 6 June, Mr Scott rang his friend and left her a voicemail, saying that he felt down and depressed. On 10 June, Mr Scott telephoned the same friend and told her that he was going for release and had filled in the documents. He spoke about the last time he had been released and how he had felt overwhelmed and unable to cope in the community. Mr Scott said that he wanted to get on with his life this time. They spoke about his friend's illness and how she hoped she did not die before he was released. Mr Scott said that he found it upsetting that she was ill because he really liked her.

59. On 12 June, Mr Scott telephoned his aunt and said that he was worried about how long his friend had left to live. He also spoke about his frustration at not being employed in prison which meant that he was in his cell a lot and did not have much money. Mr Scott said that his parents did not want any contact with him. He then telephoned his friend and they spoke for 30 minutes about life in general. He told her that he wanted to be released and make memories in the community.

Events of 13-14 June 2022

60. At around 2.00pm on 13 June, his POM spoke to Mr Scott and a prisoner for around ten minutes on the wing. She told the investigator that they were complaining about the lack of opportunities on the wing and that the regime was not running as intended. Mr Scott said that he was locked in his cell most of the time and reiterated that he wanted a job. Mr Scott also said that his friend had told him that she had only a year to live. He told her that this made him more determined to be released so that they could spend some time together. He said that he had been exercising in his cell, had lost weight and was feeling better about himself. She said that Mr Scott did not seem distressed and she had no concerns that he posed a risk to himself.

61. Prisoners were unlocked for association at around 4.15pm. CCTV footage shows that Mr Scott went in and out of his cell and spoke to officers and staff. A CM said that staff had asked her to speak to Mr Scott because he was nervous about sharing a cell when they moved back to G wing the next day. She went to speak to him with another member of staff. The CM told us that she reassured Mr Scott that he would have a nice, large cell with a new mattress and furniture. She told him the name of the prisoner with whom he would share a cell with and suggested that they should met beforehand. Later on, the CM saw them talking to each other and when she asked how things were going, Mr Scott gave her a thumbs-up sign. She said that Mr Scott did not raise any concerns about sharing a cell nor did she have any concerns that he was a risk to himself.

62. The prisoner told the investigator that he thought that Mr Scott was scared and concerned about sharing a cell. The second prisoner said that Mr Scott told him that the CM had told him that if he did not share a cell, he would be put on report and taken off the regime. The CM said that she did not say this. She said that her focus was on supporting prisoners to overcome any barriers they had with complying with the regime.

63. The second prisoner said that he thought that Mr Scott seemed fine. He told us that Mr Scott had previously shared cells but had had trouble with cellmates. He thought that this must have been on his mind.

64. An officer said that prisoners on the wing had started packing their belongings to prepare for their move the next day. When she saw Mr Scott, he had already packed some of his bags and he gave her his canteen sheet. She said that they joked together about the warm weather and moving everything in the heat. She had no concerns about Mr Scott.

65. At 6.16pm, Mr Scott telephoned his friend and they spoke about his plans for release. He said that he was moving wings the next day and he had been told that if he did not share a cell, he would be moved from the Hope Unit and subject to a disciplinary hearing. The phone cut off.

66. At 6.25pm, CCTV footage shows that Mr Scott walked down the wing stairs and into his cell. An officer locked his cell. At 6.29pm, an officer checked Mr Scott's cell door was locked and looked in through the cell door observation panel.

67. Mr Scott called his friend at 7.25pm and they spoke for six minutes about daily life. He called the same friend at 7.46pm and they spoke for twelve minutes. They spoke about him moving wings the next day and how he was not looking forward to sharing a cell. He said that an officer had told him that he would get put on report and removed from the unit if he did not move, which he was unhappy about. He told his friend that he had met the prisoner with whom he would share a cell and he seemed nice so he would give it a go. Mr Scott said that he had spoken to his POM and was not happy with the security entries in his file which she had tried to reassure him about. He said that he would go for parole and she had been supportive of this. His friend said that she would support Mr Scott when he was released. Mr Scott ran out of telephone credit and the call cut off.

68. At 8.02pm, an Operational Support Grade (OSG) checked Mr Scott's door was locked and appeared to look through his observation panel briefly as part of a roll check. The OSG told us that during a roll check, he ensured that a prisoner was in their cell and well. He could not remember what Mr Scott was doing when he checked on him.

69. On 14 June, the OSG was completing another a roll check and got to Mr Scott's cell at 5.35am. Mr Scott had covered the observation panel with toilet paper and did not respond to the OSG when he banged on the door. The OSG went to the wing office and telephoned the control room to ask for help with opening Mr Scott's door. At 5.37am, the control room asked staff attend C wing. The OSG checked on other prisoners and then returned to try to get a response from Mr Scott. He looked through a crack in the side of the door and could see that Mr Scott had a ligature around his neck, tied to the top bunk, and that his face looked drained of colour. The OSG told the investigator that he knew that Mr Scott had died. At 5.38am, the OSG radioed a medical emergency code blue (indicating that a prisoner is not breathing or is having difficulty breathing) on D1 landing, which the control room repeated as a code blue on C wing. At 5.41am, control room staff radioed to confirm whether an ambulance was needed. At 5.44am, they noted that the ambulance was estimated to arrive in 23 minutes.

70. Two officers responded to the emergency code. They attended C wing before they were redirected to D wing. They got to Mr Scott's cell seven minutes after OSG Ringrose first looked into the cell. The officers noted that Mr Scott's observation panel had been covered with toilet paper so they looked through the crack in the side of the door and could see that Mr Scott was slumped at the end of the bed and appeared to be hanging. An officer immediately unlocked the door but had difficulty pushing it open because Mr Scott's legs were in the way. The OSG supported Mr Scott's weight while an officer cut the ligature from the top bunk of the bed. They lay Mr Scott on the ground and said that they could see immediately that Mr Scott had died so did not try to resuscitate him.

71. A CM responded a minute after the other officers. They told him that Mr Scott had died. He went into the cell and noted that Mr Scott was showing signs of death. A nurse arrived for her shift at around 6.30am. She was informed of Mr Scott's death and told that an ambulance had been called but paramedics had not yet arrived. She went to Mr Scott's cell at 7.00am and following an examination, she confirmed that he had died.

72. Prison staff had told the ambulance service that Mr Scott had signs of rigor mortis. At 6.35am, staff rang 999 again to find out how long the ambulance would be and were told that they could not estimate the time of arrival because ambulances had been redirected to higher priority calls. At 7.32am, the ambulance arrived at the prison. Paramedics went to Mr Scott's cell and confirmed that he had died at 7.47am.

73. After Mr Scott had died, a prisoner said that another prisoner told him that Mr Scott had told him that he would harm himself if he had to share a cell. The prisoner told him that he had told a member of staff about this before Mr Scott's death. He said that he did not want to name the prisoner who told him because he did not know if they were telling the truth. Staff to whom we spoke said that they were unaware of this information until after Mr Scott had died.

Contact with Mr Scott's family

74. On 14 June, an officer was allocated as the family liaison officer (FLO). At 9.45am, she visited Mr Scott's next of kin with a deputy governor. They broke the news of Mr Scott's death and offered their condolences. The prison offered a contribution to Mr Scott's funeral expenses in line with national policy and stayed in contact with his next of kin.

Support for prisoners and staff

75. After Mr Scott's death, the governor debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

76. The prison posted notices informing other prisoners of Mr Scott's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Scott's death.

Post-mortem report

77. The post-mortem report found that Mr Scott died from hanging. Post-mortem toxicology results did not identify any substances in Mr Scott's system.

Findings

Assessment and management of risk

78. Prison Service Instruction (PSI) 64/2011, *Safer Custody*, lists risk factors and potential triggers for suicide and self-harm. Any prisoner identified as at risk of suicide and self-harm must be managed under ACCT procedures. PSI 64/2011 also states that any information that becomes available which may affect a prisoner's risk of harm to himself must be recorded and shared to inform proper decision-making.

79. Mr Scott moved to the Hope Unit over three months before his death, with the aim of progressing towards his release. It is clear from conversations that Mr Scott had with staff, other prisoners and his friends and family that he did not feel that he was progressing and felt frustrated about the limited regime and his lack of employment. We found that Mr Scott spent around 21 hours a day locked in his cell.

80. Mr Scott had been in prison for thirty years and all of his adult life, with the exception of two short periods in the community. He had found it difficult to cope in the community, and a psychology assessment completed in 2021 assessed that this was due to the time that he had spent in prison. Mr Scott said that he was looking forward to being released but was also concerned about how he would cope based on previous experiences. It appears that the combination of Mr Scott's long period of imprisonment, lack of sentence progression and the limitations on the regime had affected his wellbeing and sense of hope for the future at times. We found evidence that staff were aware of and supporting Mr Scott to address his concerns about release and life in the community.

81. Mr Scott was also worried about a close friend who was seriously ill. He wanted to work towards release so that they could spend time together and completed a form to ask to be considered for release at his next parole review. Staff were unaware of his friend's illness.

82. On 7 May, Mr Scott told his aunt that he had been feeling suicidal for a few days. However, his calls were not monitored. (Prisoners' calls are not routinely monitored, unless specific risks have been identified.) Staff were therefore unaware of this. He also spoke of plans for the future and his release. On 13 June, Mr Scott told his friend about his move to another wing the following day and, although he was not happy about having to share a cell, there was no indication that he posed a risk to himself. He said that he would give it a go and he submitted his canteen request. He joked with a staff member about the weather and the impact on the move. We found no evidence that Mr Scott told staff that he would harm himself if he shared a cell.

83. While Mr Scott showed signs of frustration with the regime and lack of sentence progression, he was also very engaged and motivated to work towards release and was making plans for the future. Staff were unaware of the suicidal thoughts that Mr Scott had shared with his aunt on 7 May and his friend's serious illness. They did not see any signs that he was in crisis in the period before his death.

Meaningful contact

84. Prisoners should have around 45 minutes of key work with an allocated officer each week. Only one key worker session was attempted during Mr Scott's four months at Humber, and it was cut short when the officer had to attend other duties. No information about the conversation was recorded.

85. The governor told us that the prison was experiencing major staffing shortages and was a COVID-19 outbreak site between January and April. She said that the temporary relocation of the Hope Unit was an added challenge. She explained that at the time of Mr Scott's death, they had about 140 out of 194 officers working and the shortfall was made up of staff vacancies and those on sick leave.

86. The governor was aware that the key worker scheme was not running as it should be during the time that Mr Scott lived there. She told us that she had prioritised prisoners who were considered the most vulnerable. The management team at Humber complete a weekly regime management plan which considers the staffing prediction for the following week and prioritises regime tasks accordingly. This system ensures that prisoners have showers, visits and exercise. She prioritised prisoners mixing socially (known as 'association'). She said that it was not possible to run the key worker scheme within the resources she had at the time but was keen to reinstate it and had been involved in national discussions about its function and what was achievable. She said that before COVID-19, the key worker scheme had been working well at Humber.

87. The Head of Offender Management Services, said that at the time of interview in July 2022, they were trying to expand key worker sessions to more prisoners and were developing training to ensure that staff delivered quality sessions. She said that if staff were not able to engage with a prisoner, she would expect them to speak to their POM, but recognised that staff needed further training about this.

Meaningful activity and sentence progression

88. Mr Scott was transferred to Humber to progress his sentence after he was excluded from open conditions. He had applied to the Hope Unit following advice from his probation practitioners when he said that he was worried about his readiness for release. In many of his conversations with staff, family and friends, he shared his motivation to prepare for it.

89. When he arrived, prisoners in the Hope Unit had been relocated to a different unit due to refurbishments. Staffing shortages were affecting all regimes and the availability of employment and other progressive activities for Hope Unit residents. Mr Scott was understandably frustrated by this and anxious about the impact that it might have on his planning for and prospect of release. A CM told the investigator that the number of prisoners employed on the unit was increasing daily. With the staff shortages and temporary relocation of the unit at the time, it is difficult to determine what more the Governor could reasonably have done to prioritise the regime with the resources she had and with COVID-19 restrictions in place that were outside of her control. We recognise that some of the challenges such as the relocation of the unit and COVID-19 restrictions would have been addressed or the impact reduced over time, and Mr Scott's experience might have improved. However, we consider it important that Hope Unit staff alert the sending prison to

limitations on progression activities as part of the application process before transfer. This would enable staff at the sending prison to consider the management of expectations for prisoners.

90. We are concerned about the impact of staffing shortages at Humber on all prisoners. In Mr Scott's case, this affected three vital elements of the regime: meaningful contact, meaningful activity and sentence progression opportunities. Although we cannot say for certain, it is possible that this also affected his wellbeing and risk of harm to himself. We make the following recommendation:

The Director General of Prisons and MoJ People Group should consider what additional support can be put in place to address staffing shortages at Humber and consider how it can reasonably deliver a meaningful regime and deliver key work in these circumstances.

Clinical care

91. The clinical reviewer concluded that Mr Scott's clinical care was of a good standard and equivalent to that which he could have received in the community. They noted clear evidence of multidisciplinary working and were satisfied that Mr Scott had timely and responsive reviews by members of the multidisciplinary team.

Risk from others

92. On 6 May, staff saw Mr Scott fighting with another prisoner and noted that a CSIP would be opened to support him after the incident and address the behaviour. This was never opened. A CSIP might have provided an opportunity to ensure that Mr Scott was not a risk to others and that he felt safe himself. However, staff spoke to him about the incident in the following days and did not find any issues arising or cause for concern. We have found no evidence that Mr Scott was at risk from other prisoners when he died and the other prisoner with whom he had had an altercation was no longer at the prison. Nevertheless, we bring to the Governor's attention the need to open CSIPs where prisoners may be at risk from or a risk to other prisoners.

Emergency response

93. Prison Service Instruction (PSI) 03/2013, *Medical Emergency Response Codes*, requires prisons to have a two-code medical emergency response system. Humber's local policy instructs staff to use a code blue where a prisoner is unconscious or otherwise shows signs of breathing difficulties. Calling an emergency medical code should automatically trigger the control room to call an ambulance and for healthcare staff to attend with the appropriate medical equipment.

94. PSI 24/2011, *Management and Security of Nights*, states that under normal circumstances, authority to unlock a cell at night must be given by the Night Orderly Officer (NOO) and no cell will be opened unless a minimum of two or three staff are present, one of whom should be the NOO. However, the PSI goes on to say:

> "Staff have a duty of care to prisoners, themselves and to other staff. The preservation of life must take precedence … Where there is, or appears to be, immediate danger to life, then cells may be unlocked without the authority of the NOO … and an individual member of staff may enter the cell on their own."

95. The PSI also says that staff should not take action that they feel would put themselves in unnecessary danger, that staff must make every effort to get a verbal response from the prisoner first, that they must make a rapid dynamic risk assessment on whether to enter the cell immediately or wait for assistance, and that they must inform the communications room before entering the cell.

96. The PSI requires that where observation panels are covered, the NOO should be informed immediately and staff deployed to the cell.

97. When the OSG first checked Mr Scott's cell, he could not see through the observation panel because Mr Scott had blocked it. When Mr Scott did not respond to him, he went to the wing office and telephoned the control room for further aid. He then continued to check other prisoners and returned to the cell three minutes later. At this stage, he looked through the crack in the door and noticed that Mr Scott was hanging so radioed a code blue and waited for staff to arrive before going in. Unfortunately, staff were initially sent to the wrong wing and arrived at Mr Scott's cell seven minutes after the OSG had first looked in.

98. The OSG said that he did not initially radio a code blue because a lot of prisoners covered their observation panels at Humber, and he did not believe it was an emergency situation. We are not satisfied with this explanation. It is vital for both security and safety reasons that staff can see prisoners in their cells when they are checking them to assure themselves that the prisoner is safe. Staff must challenge prisoners who cover their panels and if they are not responding, they should request immediate emergency assistance. We make the following recommendation:

The Governor should ensure that staff respond appropriately to blocked observation panels to ensure the security and safety of prisoners, and that managers support staff to enforce this.

99. Once the OSG had returned to the cell and realised that Mr Scott was hanging, he said that he would have considered going into the cell but did not do so because knew that Mr Scott was dead. He said that if he had thought that Mr Scott could have been saved, he would have done a 'dynamic risk assessment' as required by policy to determine whether to go into his cell alone. We do not consider that it was sufficient for the OSG to determine through a crack in the door and from outside the cell that Mr Scott had died.

100. It took staff four minutes to arrive after the OSG had radioed the code blue. This delay would not have made a difference to the outcome for Mr Scott but it may do in other situations. We therefore make the following recommendation:

The Governor should remind staff that, subject to a risk assessment, they should enter cells as quickly as possible if there is reason to consider that a prisoner may be at risk.

101. We also note that when the control room directed other officers to the cell, the location of the emergency they provided was initially inaccurate. This created a further delay in the emergency response. In addition, the control room staff noted the code blue at 5.38am and they called the unit at 5.41am to determine if an ambulance was needed. They noted the ambulance's estimated time of arrival as 5.44am. The exact time of the request for an ambulance is not known but it appears that there was a delay of at least three minutes. The ambulance should have been called as soon as the code blue was radioed. We recognise that these factors did not affect the outcome for Mr Scott but they might save a life in a future emergency and should be addressed. We make the following recommendation:

The Governor should ensure that control room staff accurately communicate the location of an incident and request an ambulance as soon as an emergency code is radioed.

Kimberley Bingham
Acting Prisons and Probation Ombudsman **June 2023**

Inquest

102. The inquest into Mr Scott's death concluded in December 2024. It found that Mr Scott died of suicide.

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